PS COMMITTEE #4
July 24, 2008
Worksession

Please save this packet for future reference. Most materials in this packet will not be reprinted in later Committee packets.

MEMORANDUM

TO: Public Safety Committee

FROM: Michael Faden, Senior Legislative Attorney
Minna K. Davidson, Legislative Analyst

SUBJECT: **Worksession**: Bill 25-08, *Emergency medical Service Transport Fee - Imposition*

The following are expected to attend this worksession:
Kathleen Boucher, Assistant Chief Administrative Officer
Tom Carr, Fire Chief, Montgomery County Fire and Rescue Service (MCFRS)
Scott Graham, Assistant Chief, MCFRS
Joe Beach, Director, Office of Management and Budget (OMB)

Bill 25-08 was introduced on June 10 by the Council President at the request of the County Executive, the Public Safety Committee received an overview of the Emergency Medical Services Transport (EMST) fee on June 26, and the Council held a public hearing on July 8.

Bill 25-08, *Emergency Medical Services Transport Fee – Imposition*, would authorize the Fire and Rescue Service to impose and collect a fee to recover costs generated by providing emergency medical service transports. This bill would also provide for a schedule of emergency medical services, transport fees, fee waiver criteria, permitted uses of fee revenues and other procedures to operate the emergency medical services fee program. Bill 25-08 would prohibit a local fire and rescue department from imposing a separate emergency medical services transport fee. The Executive would be required to issue regulations to implement the fee; a proposed regulation was advertised in the June County Register.

During the public hearing, Councilmembers and speakers raised several questions regarding issues that are central to implementing the EMST fee. The questions, which Council staff sent to Executive staff on July 14, are listed below. In our view, this worksession could usefully focus on these questions. Executive staff is researching these issues and will be prepared to discuss them at this worksession.

Questions from the Public Hearing

Impact of EMST fee on calls for service

1. How many refusals for EMS transport were filed per year before Fairfax County passed its law, and how many were filed after? Please provide the same information for Frederick and Howard Counties.[1]

2. In public hearing testimony, John Bentivoglio (Bethesda-Chevy Chase Rescue Squad) cited two journal articles that indicated that economic concerns might influence a patient's decision regarding the use of EMS service (see ©75-78). Please explain Executive staff's understanding of the findings in these articles, and the extent to which the findings indicate that charging an EMST fee might discourage individuals from calling 911 in a medical emergency.

Exempting the uninsured

3. William Sullivan provided a letter (see ©79-81) from the Government Employees Health Association (GEHA) stating that GEHA would deny a claim for a Montgomery County EMST fee because GEHA will not cover services or supplies for which no charge would be made if the covered individual had no health insurance. Other insurance programs contain similar exclusions. What would be the impact of this type of exclusion on the County's EMST fee as currently proposed?

4. Are Fairfax/Frederick/Howard Counties able to collect an EMST fee from federal workers insured by GEHA? If so, how are their processes different from the Executive's proposal?

5. Please provide drafts of any correspondence, statements, or forms that would be sent to uninsured Montgomery County residents under the proposed EMST fee.

6. Please provide drafts of the same documents, but for non-residents.

7. Please provide copies of Fairfax County's correspondence and waiver form for uninsured individuals.

8. How many residents have filed for an EMST fee waiver in Fairfax in each year since the fee was imposed?

Good Samaritan Law

9. Erin Gilland Roby (see email on ©86 and associated legal materials on ©87-114) argued that if the County charges an EMST fee, immunity from lawsuits will end for career and volunteer personnel. Does the County Attorney agree with this interpretation?

[1] After Council staff forwarded this question, we were informed that Howard County does not have an EMST fee.

10. If so, what are the implications for the County and for career and volunteer fire and rescue personnel?

11. If not, what is the County Attorney's understanding about the impact of an EMST fee on protections under the Good Samaritan law?

Impact of EMST fee on Local Fire and Rescue Departments

12. A representative of the Wheaton Volunteer Rescue Squad testified that its charter does not permit them to charge a fee (see ©84-85). Do other LFRD charters prohibit charging fees? How does the Executive's proposed EMST fee reconcile with LFRD charter prohibitions against charging fees?

13. Do Fairfax/Frederick/Howard Counties' volunteer fire and rescue departments have any information on fundraising before and after the imposition of EMST fees?

Secondary insurance

14. If a patient has private insurance in addition to Medicare, does the private insurance pay the excess over any Medicare reimbursement for EMS transport?

15. If a patient is covered under more than one group or private insurance plan, does the secondary insurance pay the excess over any primary insurance reimbursement for EMS transport?

Coordination with hospitals

16. How will the County (or a third party administrator) coordinate with hospitals to collect billing information? Will the procedures be the same for each hospital? If not, how much will the procedures have to be adjusted for each hospital?

In addition to these post-hearing questions, the Public Safety Committee previously requested responses to Council staff questions on the fiscal impact and revenue assumptions for the bill. Responses from Executive staff, received on July 23, are on ©43-48. Executive staff will be available to discuss the responses in more detail at this worksession.

For reference, this packet includes several items that were previously transmitted for the Public Safety Committee's overview session. They are attached as indicated in the table of contents.

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F:\LAW\BILLS\0825 Emer.Med.Svc.Fee\080724 PS Memo

Bill No. 25-08
Concerning: Emergency Medical Services Transport Fee – Imposition
Revised: _____ Draft No. ____
Introduced: June 10, 2008
Expires: December 10, 2009
Enacted: _____
Executive: _____
Effective: _____
Sunset Date: None
Ch. _____, Laws of Mont. Co. _____

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President at the request of the County Executive

AN ACT to:

(1) authorize the Fire and Rescue service to impose and collect a fee to recover costs generated by providing emergency medical service transports;
(2) provide for a schedule of emergency medical services transport fees, fee waiver criteria, permitted uses of fee revenues, and other procedures to operate the emergency medical services fee program;
(3) prohibit a Local Fire and Rescue Department from imposing a separate emergency medical services transport fee;
(4) require the Executive to issue certain regulations to implement an emergency medical services transport fee; and
(5) generally amend County law regarding the provision of emergency medical services.

By adding
Montgomery County Code
Chapter 21, Fire and Rescue Service
Section 21-23A

Boldface	*Heading or defined term.*
Underlining	*Added to existing law by original bill.*
[Single boldface brackets]	*Deleted from existing law by original bill.*
Double underlining	*Added by amendment.*
[[Double boldface brackets]]	*Deleted from existing law or the bill by amendment.*
* * *	*Existing law unaffected by bill.*

The County Council for Montgomery County, Maryland approves the following Act:

Sec. 1. Section 21-23A is added as follows:

21-23A Emergency Medical Services Transport Fee.

(a) Definitions.

In this section the following terms have the meanings indicated:

(1) Emergency medical services transport means the transportation by the Fire and Rescue Service of an individual by ambulance. Emergency medical services transport does not include the transportation of an individual under an agreement between the County and a health care facility.

(2) Federal poverty guidelines means the applicable health care poverty guidelines published in the Federal Register or otherwise issued by the federal Department of Health and Human Services.

(3) Fire and Rescue Service includes each local fire and rescue department.

(b) Imposition of fee. The Fire and Rescue Service must impose a fee for any emergency medical service transport provided in the County and, unless prohibited, outside the County under a mutual aid agreement.

(c) Liability for fee.

(1) A County resident is responsible for the payment of the emergency medical services transport fee only to the extent of the resident's available insurance coverage.

(2) Subject to subsection (d), all other individuals are responsible for payment of the emergency medical services transport fee without regard to insurance coverage.

(d) Hardship waiver.

(1) The Fire Chief must waive the emergency medical services transport fee for any individual who is indigent under the federal

poverty guidelines. An individual must request a waiver on a form approved by the Fire Chief.

(2) The Fire Chief may deny a request for a waiver if the individual who claims financial hardship under this Section does not furnish all information required by the Fire Chief.

(e) Obligation to transport. The Fire and Rescue Service must provide emergency medical services transport to each individual without regard to the individual's ability to pay.

(f) Restriction on Local Fire and Rescue Departments. A local fire and rescue department must not impose a separate fee for an emergency medical transport.

(g) Use of revenue. The revenues collected from the emergency medical services transport fee must be used to supplement, and must not supplant, existing expenditures for emergency medical services and other related fire and rescue services provided by the Fire and Rescue Service.

(h) Regulations; fee schedule. The County Executive must adopt a regulation under method (2) to implement the emergency medical service transport fee program. The regulation must establish a fee schedule based on the cost of providing emergency medical services transport. The fee schedule may include an annual automatic adjustment based on inflation, as measured by an index reasonably related to the cost of providing emergency medical services transports. The regulation may require individuals who receive an emergency medical services transport to provide financial information, including the individual's insurance coverage, and to assign insurance benefits to the County.

LEGISLATIVE REQUEST REPORT

Bill No. 25-08
Emergency Medical Services Transport Fee – Imposition

DESCRIPTION:	This bill provides the Montgomery County Fire and Rescue Service (MCFRS) with the authority to collect fees for the provision of emergency medical services. The bill includes a waiver provision for individuals who meet certain low income criteria.
PROBLEM:	The costs incurred in providing emergency medical services are not fully covered by the Fire Tax District property tax. These costs include the Apparatus Management Plan, EMS quality assurance, staffing, enhancing EMS capacity, and acquisition of other equipment and technology to support the provision of emergency medical services.
GOALS AND OBJECTIVES:	The goal of this bill is to increase the resources available to fund critically needed improvements to the MCFRS.
COORDINATION:	County Executive's Office, MCFRS
FISCAL IMPACT:	To be requested.
ECONOMIC IMPACT:	To be requested.
EVALUATION:	Subject to the oversight of MCFRS, the County Executive, and the County Council.
EXPERIENCE ELSEWHERE:	Most area jurisdictions have successfully implemented similar programs which have provided additional resources to fund improvements needed for EMS services. These jurisdictions include Fairfax County, Prince George's County, Baltimore City, Frederick County, Arlington County, and the District of Columbia.
SOURCE OF INFORMATION:	Scott Graham, Assistant Chief, Fire and Rescue Service 240-777-2493.
APPLICATION:	Applies to EMS transports within municipalities.
PENALTIES:	Not applicable.

① BILL
② EXEC REG

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OFFICE OF THE COUNTY EXECUTIVE
ROCKVILLE, MARYLAND 20850

Isiah Leggett
County Executive

034623

MEMORANDUM

April 11, 2008

Method 2

TO: Michael J. Knapp, President
Montgomery County Council

FROM: Isiah Leggett, County Executive

SUBJECT: Emergency Medical Transport Fee

I am attaching for the Council's consideration a bill which would authorize the Montgomery County Fire and Rescue Service (MCFRS) to impose an Emergency Medical Services Transport Fee (EMST Fee). I am also attaching a Legislative Request Report and a draft Executive Regulation which is provided for information purposes only to reflect the Executive's intent regarding implementation of the proposed bill.

The EMST Fee will generate revenues that will allow the County to keep pace with the public safety demands of our growing community by funding: (1) continued support of the approved Apparatus Management Plan; (2) volunteer recruitment and retention; (3) continued implementation of a phased plan to provide four-person staffing on front line fire apparatus to move towards compliance with NFPA Standard 1710 and improve the response times of Advanced Life Support service; and (4) other operating budget support for MCFRS.

Implementing the programs listed above will require incremental improvements under a multi-year plan. The EMST Fee will provide an ongoing revenue source that will help fund that plan. I will continue to make recommendations for critical improvements to the MCFRS in the annual operating budget process.

In most cases, the EMST Fee will be billed directly to an individual's health insurer. County residents without insurance will not pay for emergency transports to the hospital. All of the region's surrounding jurisdictions have implemented similar fees without reducing the willingness of individuals to call for emergency service transports.

I look forward to working with Council in addressing the priority needs of the MCFRS to assure that we adequately meet the public safety needs of our growing community.

IL:jgs

Attachments

(5)

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Montgomery County Regulation on

EMERGENCY MEDICAL SERVICE TRANSPORT FEES

Issued by: County Executive
Regulation No. _____
COMCOR: Chapter 21
Authority: Code Section 21-23A
Supersedes: N/A
Council Review: Method (2) under Code Section 2A-15
Register Vol. ____ No. ____
Effective Date: Date Bill titled "Emergency Medical Services Transport Fee – Imposition" becomes effective
Comment Deadline: _____

Summary: This Regulation establishes: (1) An emergency medical services transport fee schedule; and (2) a requirement that an individual who receives an emergency medical services transport provide certain information and execute an assignment of certain health insurance benefits.

Staff contact: Scott Graham, Assistant Chief, Montgomery County Fire and Rescue Service
(240) 777-2493

Address: Montgomery County Fire and Rescue Service
101 Monroe Street, 12th Floor
Rockville, Maryland 20850

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Section 1. Fee Schedule

a. In imposing and collecting the emergency medical services transport fee authorized under Code Section 21-23A, the Fire Chief must comply with all applicable provisions of 42 CFR Parts 410 and 414, *Fee Schedule for payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Non-emergency Ambulance Services.*

b. The Fire Chief must impose the emergency medical services transport fee according to the following schedule:

i. $7.50 per mile, one way, from point of pick up to the health care facility; plus

ii.

• Basic Life Support – Non-emergency*	$300.00
• Basic Life Support – Emergency*	$400.00
• Advanced Life Support – Level 1 – Non-Emergency*	$350.00
• Advanced Life Support – Level 1 – Emergency*	$500.00
• Advance Life Support – Level 2*	$700.00
• Specialty Care Transport*	$800.00

* The terms in the schedule are as defined in 42 CFR Parts 410 and 414.

Section 2. Required Information; Assignment of Benefits.

a. Each individual who receives an emergency medical services transport must furnish to the County, or its designated agent or contractor: (i) information pertaining to the individual's health insurer (or other applicable insurer); and (ii) financial information that the Fire Chief determines is necessary for collection of the fee.

b. Each insured individual who receives an emergency medical services transport must execute an assignment of benefits form necessary to permit the County to submit a claim for the fee to the applicable third party payor.

c. The Fire Chief must increase the amount of the fees in the schedule annually by the amount of the Ambulance Inflation Factor (AIF) as published by the Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services.

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Section 3. Severability.

If a court of final appeal holds that any part of this regulation is invalid, that ruling does not affect the validity of other parts of the regulation.

Section 4. Effective Date.

This regulation is effective on the date the Bill titled "Emergency Medical Services Transport Fee – Imposition" becomes effective.

Approved:

_____

Isiah Leggett, County Executive

MONTGOMERY COUNTY MARYLAND

Proposed Executive Regulations

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MCER NO. 20-08: PROPOSED MONTGOMERY COUNTY FIRE AND RESCUE REGULATION – *Emergency Medical Service Transport Fee*

SUMMARY: The proposed regulation establishes (1) an Emergency Medical Services Transport Fee (EMS Transport Fee) schedule; and (2) a requirement that an individual who receives an Emergency Medical Services transport provide certain information and execute an assignment of certain health insurance benefits. The fee schedule, including the mileage rate, may be amended based on any additional financial analysis received before approval of the final regulation. An amendment will be considered to establish a process or formula to distribute a portion of the revenue received from the EMS fee to the Local Fire and Rescue Departments. Comment is invited on an appropriate process or formula for distributing revenue from the EMS fee to the Local Fire and Rescue Departments.

COMMENTS: Written comments must be submitted by July 1, 2008, to Assistant Chief Scott Graham, MCFRS, Montgomery County Fire and Rescue Service/Office of the Fire Chief, 101 Monroe Street, 12th Floor, Rockville, Maryland 20850; 240/777-2493. scott.graham@montgomerycountymd.gov

AUTHORIZATION AND PROCEDURAL METHOD: Montgomery County Code, 2004, Section 21-23A.
Method 2.

COPIES OF THE PROPOSED REGULATION: A copy of the proposed regulation may be obtained from to Assistant Chief Scott Graham, MCFRS, Montgomery County Fire and Rescue Service/Office of the Fire Chief, 101 Monroe Street, 12th Floor, Rockville, Maryland 20850; 240/777-2493.
scott.graham@montgomerycountymd.gov

MCER NO. 21-08: PROPOSED ETHICS COMMISSION REGULATION – *Lobbyist Registration Fee*

SUMMARY: The proposed regulation implements section 19A-23(e) which permits he Ethics Commission to charge an annual registration fee for lobbyists.

COMMENTS: Written comments must be submitted by June 30, 2008, to Barbara McNally, 100 Maryland Avenue, #204, Rockville, Maryland 20850; 240/777-6670.
barbara.mcnally@montgomerycountymd.gov

AUTHORIZATION AND PROCEDURAL METHOD: Montgomery County Code, 2004, Section 19A-23(e). Method 2.

COPIES OF THE PROPOSED REGULATION: A copy of the proposed regulation may be obtained from Barry Alpher, Ethics Commission, 100 Maryland Avenue, #204, Rockville, Maryland 20850. barry.alpher@montgomerycountymd.gov

MCER NO. 22-08: PROPOSED OFFICE OF HUMAN RESOURCES REGULATION –

(9)

BILL 25-08

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OFFICES OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

May 13, 2008

TO: Michael J. Knapp, Council President

FROM: Timothy L. Firestine, Chief Administrative Officer

SUBJECT: Emergency Medical Services Transport Fee

On April 11, 2008, County Executive Isiah Leggett forwarded to Council a bill that would authorize the Montgomery County Fire and Rescue Service (MCFRS) to impose an Emergency Medical Services Transport Fee (EMST Fee). He also forwarded a draft Executive Regulation which would implement that bill. In order to ensure that all relevant details of the EMST Fee are considered as a package, the proposed Executive Regulation will be published in the June 2008 Montgomery County Register.

With this memorandum, I am forwarding an Implementation Plan for the (EMST) Fee. While this type of fee will be new to Montgomery County, similar fees have already been implemented in hundreds of jurisdictions nationally and by several local governments in this region including Fairfax County, Arlington County, the District of Columbia, and Prince George's County. In addition, the County Government, the Department of Finance, and MCFRS administer fee collection operations that match or exceed the complexity and magnitude of the proposed EMST Fee. The attached plan indicates that both in inception and in implementation the EMST Fee will:

- Support the continued provision of first-class emergency medical services transport to all in need;
- Charge Medicare and health insurance companies for emergency medical service transport costs incurred by County residents and non-County residents;
- Result in no out-of-pocket expenses for insured County residents and no charge for uninsured County residents;
- Produce substantial non-tax supported resources to provide urgently needed enhancements to the County's combined Fire and Rescue Services; and
- Support the activities of the Local Volunteer Fire and Rescue Departments.

I look forward to discussing this plan with the Council.

TLF:jgs

IMPLEMENTATION OF AN EMERGENCY MEDICAL SERVICES TRANSPORT FEE IN MONTGOMERY COUNTY, MARYLAND

Prepared by:
Fire and Rescue Service
Office of Management and Budget
Public Information Office
Offices of the County Executive

May 13, 2008

Background

Montgomery County Fire and Rescue Service (MCFRS) provides emergency medical services (EMS) and transport through a comprehensive delivery system. This system is comprised of career and volunteer personnel, basic and advanced life support first response, as well as basic and advanced life support transports.

MCFRS staffs 24 basic life support (BLS) ambulances 24/7 and 3 BLS "Flex Units" 12 hours per day, 18 medic units, 18 Advance Life Support (ALS) engine companies, 15 engine companies, 15 truck companies, and 6 heavy rescue squads operating from strategically selected locations. MCFRS provides a response to all emergency calls for ambulance transportation within the County. Emergency response is also provided for surrounding jurisdictions under mutual aid agreements. MCFRS responds to approximately 70,000 EMS calls per year.

Problem

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands, improve response time, and enhance firefighter/rescuer officer safety, several enhancements have been initiated within MCFRS and will require additional resources in the future including:

- Implementing four-person staffing. The County has initiated the first two phases of this seven phase plan.
- Opening new stations in the Upcounty area including Travilah, West Germantown, East Germantown, and Clarksburg.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting System (e-PCR). On December 31, 2008, the Maryland Institute for Emergency Medical Services Systems will discontinue paper reporting. Currently MCFRS utilizes this method. MCFRS must quickly implement on a fast track, an e-PCR program in order to meet State of Maryland requirements as well as be fully capable of complete revenue recovery.
- Expanding the number of Captains consistent with supervisory and work hour requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.

The table below summarizes the projected costs of some of these initiatives.

Potential Use of Resources	FY09	FY10	FY11	FY12	Total
Operating Budget Impact - Staffing New Stations	$ 3,017,430	$ 6,327,000	$ 6,585,000	$ 9,284,000	$ 25,213,430
Apparatus Management Plan***		$ 7,000,000	$ 7,840,000	$ 8,780,800	$ 23,620,800
4 Person Staffing Phases 3-7		$ 4,101,000	$ 8,494,094	$ 13,200,086	$ 25,795,179
Total (Potential Use of Resources)	**$ 3,017,430**	**$ 17,428,000**	**$ 22,919,094**	**$ 31,264,886**	**$ 74,629,409**
*** Assumes 12% Cost Escalator in FY10-12					

Proposed Solution

The proposed EMST Fee will provide a substantial portion of the resources needed for these enhancements. In addition, the EMST Fee will be a dedicated revenue source that will be collected by the MCFRS and deposited in the Fire Tax District Fund. However, if these resources are not available, the County will either, not implement or partially implement these enhancements, reduce services substantially in a different part of the government, or increase property taxes to fund these improvements.

Program Revenues and Expenditures

To study the feasibility of implementing an EMST Fee, the County contracted with Page, Wolfberg, and Wirth, L.L.C. (PWW), a nationally recognized law firm specializing in Emergency Medical Services law. In conjunction with PWW, MCFRS developed the detailed financial projections for the EMST Fee. The table below summarizes the projected costs and revenues for implementing of the EMST Fee.

	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	**$ 7,047,790**	**$ 14,763,417**	**$ 15,471,092**	**$ 16,225,692**	**$ 53,507,991**
					$ -
Costs					
Third Party Billing (5%)	$ 352,390	$ 1,476,341	$ 1,547,109	$ 1,622,569	**$ 4,998,409**
Community Outreach	$ 200,000	$ 50,000	$ 50,000	$ 25,000	**$ 325,000**
Initial Personnel Training	$ -	$ 25,000	$ 25,000	$ 25,000	**$ 75,000**
Manager Billing Services*	$ 105,500	$ 113,014	$ 121,064	$ 129,686	**$ 469,264**
Quality Compliance (2)*	$ -	$ 138,055	$ 147,888	$ 158,422	**$ 444,365**
IT Specialist - Hardware*	$ 85,250	$ 91,325	$ 97,830	$ 104,798	**$ 379,203**
IT Specialist - Data Analyst*	$ -	$ 91,325	$ 97,830	$ 104,798	**$ 293,953**
Office Service Coordinator*	$ -	$ 65,935	$ 70,631	$ 75,662	**$ 212,228**
Available Revenue	**$ 6,304,650**	**$ 12,712,421**	**$ 13,313,740**	**$ 13,979,757**	**$ 46,310,569**
* Assumes a 7% increase per year					

To ensure that the revenue projections were realistic, MCFRS assumed a relatively low total transport number of 56,977. Assumptions regarding the types of transports (e.g. Basic Life Support – Emergency (BLS-E), Advance Life Support – Emergency (ALS-E), etc.) were based on MCFRS records. Fees were set in a manner consistent with other

jurisdictions and the cost of providing the services, and assumptions about payor types (e.g. Medicare, Medicaid, and Commercial Insurance) were also based on experience in other jurisdictions.

Administration of the Fee

- No person regardless of ability to pay will ever be refused EMS treatment or transport by MCFRS.
- Each EMS transport will result in a bill for service being sent to the patient's insurance company or the patient depending on two factors: Is the patient a County resident? Is the patient insured?
- Patients who reside within the county will not receive a bill for services whether they are insured or not.
- Patients who do not reside within the county and are insured will receive a bill only for the cost of the co-pay and deductible. A Request for Waiver will be included with the bill.
- Patients who do not reside within the county and are not insured will receive a bill for the services, but a Request for Waiver will be included with the bill.
- Requests for Waivers will be granted by the Fire Chief based on whether the patient's household income is within the federal poverty guidelines.
- Billing and collection functions will be contracted to a third party that specializes in EMS billing. With the rapidly changing requirements of the various insurance services, it is necessary to employ experts in this field to insure a prompt and accurate payment program.
- MCFRS will work with the local hospitals to provide insurance information to the billing contractor.
- This information will be transmitted electronically to the contracted billing vendor to facilitate collections.
- The billing vendor will be paid a negotiated fee for services. This fee is budgeted at 5% of collected revenue.

Impact on Local Fire and Rescue Departments

Our efforts to study the feasibility and impacts of implementing the EMST Fee have included numerous discussions with the LFRDs and the Montgomery County Volunteer Fire and Rescue Association (MCVFRA). The primary concerns of the LFRDs would appear to be that the EMST Fee would deter some residents from calling for emergency services and that the existence of the fee may impair their fund raising efforts.

We have found no evidence to support the claim that emergency calls for service or patient transports decline after the imposition of an EMST Fee. Similarly there is also no evidence that EMST Fees impair the development capacity of volunteer fire corporations. The County's policies and budgetary decisions should be driven by data, evidence, and best practices and not on assertions lacking any factual basis.

We have discussed with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents as well as to offset any reduction in development that may result from the establishment of an EMST Fee.

Community Outreach Plan

To ensure that County residents understand how the billing process will work and assure them that service will not be denied regardless of ability to pay we are developing a comprehensive community outreach plan.

Communities that have implemented an EMST Fee program have accompanied that program with a public outreach and education campaign. While there is no evidence from any of these jurisdictions that adoption of an EMST Fee has resulted in any diminution of calls for 911 service or emergency transport or any reluctance of residents to call for needed services due to a misunderstanding that they might incur a fee, a solid campaign of public outreach and education just makes good sense. Such a campaign would begin several months before the program actually began and extend several months afterward.

The proposal as advanced by the County Executive includes up to $200,000 for just such a campaign, to be undertaken by the County Office of Public Information in conjunction with MCFRS. Such a campaign could include:

- An informational mailer/card sent to all County households.
- Distribution of information through existing County and community email lists, blogs, and list serves.
- Radio and television public service announcements made available to the electronic media servicing the County.
- News releases and news events featuring information about the program.
- Information translated into Spanish, French, Chinese, Korean, Vietnamese, and other languages, as needed.
- Extensive use of County Cable Montgomery television and all the Public, Educational, and Government channels funded by the County.
- A speakers' bureau available to address community groups.
- Posters and brochures made available at all County events and on Ride One buses and through: Regional Service Centers; Public Libraries; Recreation facilities; senior centers; ESL classes; MCPS; Montgomery College; health care providers; hospitals and clinics; and other venues.
- Special outreach to the senior community and to the County's "New American" communities.

Through these means – and others yet to be determined – the County could communicate that, as always, the MCFRS stands ready to assist all those in need, regardless of ability to pay.

Summary

The establishment of an EMST Fee can be accomplished during FY09 which would produce substantial non-tax supported resources to support the urgently needed enhancements for the MCFRS. The table below summarizes the projected revenues, program costs, and the potential uses of the resulting fee revenues. The table also includes a comparison of the revenues that would be raised by an increase in the County's property tax rate. An increase in the property tax rate is the most feasible alternative to the EMST Fee since the property tax provides over 95 percent of the revenues for the County's Consolidated Fire Tax District Fund.

MCFRS Emergency Medical Service Transport Fee - Revenues and Use of Potential Use of Resources					
	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	**$ 7,047,790**	**$ 14,763,417**	**$ 15,471,092**	**$ 16,225,692**	**$ 53,507,991**
Costs					
Third Party Billing (5%) .	$ 352,390	$ 1,476,341	$ 1,547,109	$ 1,622,569	$ 4,998,409
Community Outreach	$ 200,000	$ 50,000	$ 50,000	$ 25,000	$ 325,000
Initial Personnel Training	$ -	$ 25,000	$ 25,000	$ 25,000	$ 75,000
Manager Billing Services*	$ 105,500	$ 113,014	$ 121,064	$ 129,686	$ 469,264
Quality Compliance (2)*	$ -	$ 138,055	$ 147,888	$ 158,422	$ 444,365
IT Specialist - Hardware*	$ 85,250	$ 91,325	$ 97,830	$ 104,798	$ 379,203
IT Specialist - Data Analyst*	$ -	$ 91,325	$ 97,830	$ 104,798	$ 293,953
Office Service Coordinator*	$ -	$ 65,935	$ 70,631	$ 75,662	$ 212,228
Available Revenue	**$ 6,304,650**	**$ 12,712,421**	**$ 13,313,740**	**$ 13,979,757**	**$ 46,310,569**
LFRD Allocation **	**$ -**	**$ 1,500,000**	**$ 1,575,000**	**$ 1,653,750**	**$ 4,728,750**
CFTD Reserves (For Electronic Patient Care Reporting System (EPCR) PC Modules and Licensing)	**$ 2,500,000**	**$ 100,000**	**$ 100,000**	**$ 100,000**	**$ 2,800,000**
Total (Program-related Expenditure)	**$ 2,500,000**	**$ 1,600,000**	**$ 1,675,000**	**$ 1,753,750**	**$ 7,528,750**
Net Revenue (After Program-related Expenditure)	**$ 3,804,650**	**$ 11,112,421**	**$ 11,638,740**	**$ 12,226,007**	**$ 38,781,819**
Other Use of Resources ****					
Operating Budget Impact - Staffing New Stations	$ 3,017,430	$ 6,327,000	$ 6,585,000	$ 9,284,000	$ 25,213,430
Apparatus Management Plan***		$ 7,000,000	$ 7,840,000	$ 8,780,800	$ 23,620,800
4 Person Staffing Phases 3-7		$ 4,101,000	$ 8,494,094	$ 13,200,086	$ 25,795,179
Total (Other Use of Resources)	**$ 3,017,430**	**$ 17,428,000**	**$ 22,919,094**	**$ 31,264,886**	**$ 74,629,409**
Net Revenue (After other use of resources)	**$ 787,220**	**$ (6,315,579)**	**$ (11,280,354)**	**$ (19,038,878)**	**$ (35,847,590)**
1 cent increase in Property Tax Rate =	**$ 16,100,000**	**$ 16,695,700**	**$ 16,979,527**	**$ 17,488,913**	**$ 67,264,140**
Note:					
* Assumes a 7% increase per year					
** Illustrative Only (details pending further discussion with LFRDs and MCVFRA). Assumes a 5% increase per year.					
*** Assumes 12% Cost Escalator					
**** Does not include other potential FRS needs including additional Captains consistent with supervisory and work hour requirements.					

OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett
County Executive

Joseph F. Beach
Director

MEMORANDUM

April 14, 2008

TO: Michael J. Knapp, Council President

FROM: Joseph F. Beach, Director, Office of Management and Budget

SUBJECT: Expedited Bill, Emergency Medical Service Transportation Fee

The purpose of this memorandum is to transmit a fiscal impact statement to the Council on the subject legislation.

LEGISLATION SUMMARY

The expedited bill will provide for a new Emergency Medical Service Transport fee to be implemented in FY09 to provide needed resources for improvements to staffing, apparatus, recruitment and retention and volunteer enhancements.

FISCAL SUMMARY

The primary fiscal impact of this legislation will be to establish an Emergency Medical Services Transportation fee as specified in the legislation.

Revenues

The projected revenues are based on a mix of four payer types: Medicare, Medicaid, Commercial/Auto Insurance and Self Pay and an average revenue per transport rate of $247 in FY09 up to $253 in FY12 and a Montgomery County Fire and Rescue Service estimated transport volume of 56,980 for FY09 which is expected to increase to 64,090 in FY12. The legislation is expected to result in revenues of $7.05 million in FY09, assuming mid-year implementation, and annual revenues of $14.8 million in FY10, $15.4 million in FY11 and $16.2 million in FY12. For additional details on the basis of these estimates please see the attached EMS Transport Revenue Projections Report prepared for the County by Page, Wolfberg, and Wirth.

Expenditures

Personnel Costs

It is expected that six additional full-time personnel will be needed for implementation: A Manager III, an Office Services Coordinator, two Quality Assurance personnel, an IT Specialist II, and a Program Manager I (Data Analyst). The Manager III and IT Specialist II will be hired in FY09, with the remainder of the staff phased-in during FY10. The FY09 salary, wages and benefits total $190,750. The annual total salary, wages and benefits, excluding any wage adjustments, will be $466,500 annually.

Operating Expenses

Operating expenses for FY09 is comprised of a third party contract expenditures of $352,390 and $200,000 for community outreach activities. In addition, funds are set aside in designated reserves in FY09 for acquisition of an Electronic Patient Care Reporting System (EPCR) to efficiently automate the management of patient information. The cost of this system and annual maintenance fees will be dependent on the vendor selected and the terms negotiated with that vendor. Total annual operating expenses for full year operation of the program are dependent, in part, on the negotiated fee for the third party contractor who will manage the billing program on behalf of the County. Also, the costs of community outreach will be reduced after the initial year of implementation because the need for these outreach activities will not be as significant when the program is fully operational.

JFB:aaa

Attachment

cc: Timothy L. Firestine, Chief Administrative Officer
Tom Carr, Chief, Montgomery County Fire and Rescue Service
Kathleen Boucher, Assistant Chief Administrative Officer
Rebecca Domaruk, Offices of the County Executive
Brady Goldsmith, OMB
Anita Aryeetey, OMB

PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION

MONTGOMERY COUNTY FIRE RESCUE SERVICES

EMS Transport Revenue Projections

Submitted By:

Page Wolfberg & Wirth

The National EMS Industry Law Firm℠

January 18, 2008

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TABLE OF CONTENTS

I. Overview

Montgomery County Fire Rescue Services (MCFRS) is evaluating the potential implementation of an EMS Transport Revenue Recovery Program. MCFRS has engaged Page, Wolfberg & Wirth, LLC (PWW), a national EMS industry law and consulting firm, to assist it in this process. Among the tasks with which PWW is charged is the development of revenue projections that might be realized in the event that the *revenue recovery program* is implemented.

When assessing potential revenues from any proposed health care billing undertaking, it must be remembered that revenue forecasting is both an art and a science; there is little in the way of published, publicly-accessible data from which meaningful comparisons to similar jurisdictions can be drawn. Whenever possible, key assumptions affecting these projections were kept on the "conservative" side, and many such assumptions are based on our experience in working with EMS systems of all *configurations* across the United States. All assumptions made in the generation of these projections will be stated so that Montgomery County elected officials, policymakers and Fire Rescue leadership can be guided accordingly.

Our detailed revenue projection spreadsheets for Years One – Four are attached to this report as Appendices A-D.

II. Methodology and Assumptions

A. Time Intervals

This report provides four (4) years of revenue projections. We utilized 2008 Medicare rates as a starting figure. The reports are presented on a Calendar Year (CY) basis. These projections were made on a CY basis primarily because Medicare (from which the single largest portion of revenues is expected to be derived) adjusts its allowed rates on a calendar year basis. CY projections can easily be converted into Fiscal Year (FY) projections by taking a pro-rata share of the annual projections and combining them with the corresponding pro-rata portion of the subsequent calendar year's projections.

B. Estimated Transport Volume

All estimated transport volumes utilized in this report were provided by MCFRS. This statistic is the key driver in any EMS transport fee revenue projection model. We note that MCFRS currently utilizes a paper patient care reporting approach, which limits both the accuracy and the quantity of available data from which these projections can be made.

C. Transport Mix by Payor

Transport mix estimates are found on the top of each spreadsheet (Exhibits A-D). The "transport mix" is the number and percentage of transports by applicable payor type.

D. Transport Mix by Level of Service

Within each payor category, we utilized a consistently estimated approach to the level of service mix (i.e., BLS vs. ALS). We believe that, compared to other jurisdictions, we have utilized a conservative mix of ALS vs. BLS transports. Many similar jurisdictions report higher ALS percentages. We felt it was best to estimate a lower percentage of transports classified with an ALS level of service, because there are several key variables which effect this determination that have yet to be made by MCFRS. A key variable is the implementation (and integration with the billing system) of a dispatch protocol that utilizes ALS/BLS response determinants. Another key variable in this area is the quality of field documentation, particularly whether the crews adequately document the elements necessary to bill for "ALS assessments" under applicable payor guidelines. This involves the documentation of the nature of dispatch, an immediate response, and the performance of an assessment by an ALS-level provider.

It is also important to note that we assigned a small (almost negligible) percentage (1%) of transports to "non-emergency" levels of service. We recognize that MCFRS is solely a 911, emergency provider. However, until dispatch protocols are fully integrated with billing systems, there is a chance that on a small percentage of calls, billers will not have the requisite emergency dispatch information available to them and, acting out of an abundance of compliance, will code the claims as "non-emergencies." That is why non-emergency levels of service are included in the model.

We also included the "Specialty Care Transport" (SCT) level of service on the spreadsheet model, though we did not assign any transports to this category. SCTs are interfacility transports, which we presume would not be handled by MCFRS, though the SCT

category is included in case MCFRS would like to investigate the financial impact of providing this type of service in the future.

We also assumed a relatively conservative 1% for "ALS2" level transports. This is a more intensive (and higher-reimbursed) level of service that applies when a patient receives such invasive interventions as endotracheal intubation.

E. Payor Type

There are four payor types utilized in these projections: Medicare, Medicaid, Commercial/Auto Insurance and Self-Pay. As a provider of emergency, 911 services only, we assumed that MCFRS will not enter into contracts with Medicare managed care ("Medicare Advantage") organizations or other commercial payors. Therefore, all transports of Medicare Advantage patients are included in the "Medicare" category. Similarly, the "Commercial/Auto Insurance" category includes commercial managed care plans, traditional indemnity "fee-for-service" plans, automobile liability insurance policies, workers compensation payments, and similar types of commercial or self-insurance.

F. Self-Pay Transports

In this model, we assumed that the County would implement an "insurance only" billing policy, under which County residents would be billed only to the extent of available insurance. Residents (and employees of business situated within the County) would not be billed for copayments, deductibles or other charges unmet by their insurance coverage (in addition, no payment would be collected from uninsured residents). As a result, we assume a conservative 10% of collections from the projected universe of self-pay patients. In other words, we assume that the vast majority of services will be provided to County residents.

G. Mileage

Medicare and most commercial payors reimburse ambulance services for "loaded" miles, i.e., for those miles which the patient is on board the ambulance, from the point of pickup to the closest appropriate destination. We made the assumption, given the geography, population centers and population density of the County, that the average transport would include five (5) loaded miles. As with all assumptions in this model, this particular assumption can be modified to determine the resulting impact on revenues if desired.

H. Charges

We included a proposed schedule of charges for each level of service. Of course, the selection of a rate schedule is entirely up to County policymakers and is typically a factor of many economic and political considerations. However, the County's charges should, without question, be a fair amount higher than the prevailing Medicare-approved rates, because, under Federal law, Medicare pays the *lesser* of the approved Medicare fee schedule amount *or* the provider's actual charges. In other words, if a provider charges *less* than the applicable Medicare fee schedule payment, Medicare does not "make up the difference." It becomes legitimate revenue that is irretrievably lost and cannot be recovered from any other source. Establishing rates that are comfortably above the approved

Medicare fee schedule amounts is a paramount consideration in the establishment of any ambulance rate schedule.

We assumed an annual increase of 5% in the County's ambulance rate schedule in years 2-4.

An article dealing with ambulance rate-setting that the County might find helpful is attached to this report as Appendix E.

I. Approved Charges

For each payor category (except, of course, for self-pay), we estimated an "approved charge." This is the amount that Medicare, Medicaid or commercial insurers will approve for the particular level of service. Medicare rates are established annually according to a national fee schedule and vary slightly based on geography (due to the incorporation of the "Geographic Practice Cost Indicator" (GPCI) from the Medicare physician fee schedule into the Medicare ambulance fee schedule. The projections assume a GPCI of 1.08, which is the 2007 GPCI for Maryland Locality 01.

Medicare rates increase annually by a modest inflation factor. In 2007, Medicare announced an Ambulance Inflation Factor (AIF) of 2.7% for dates of service January 1, 2008 – December 31, 2008. We assumed a 2.5% Medicare AIF for years 2-4. We also assumed a 2.5% increase in amounts allowed by commercial insurers. We assumed no annual increase in Maryland Medicaid rates, which are a flat $100 (ALS or BLS) with no allowance for loaded mileage.

For commercial insurers, we assumed an overall percentage of approved charges of 67%. It is very difficult to predict with certainty how this payor class will respond to the implementation of an EMS billing program. Some commercial insurers pay 100% of billed charges for emergencies without question; others take aggressive stands against paying full charges and often will pay some arbitrary amount that they deem to be "reasonable." We believe that an overall figure of 67% of charges takes these variables into account.

The difference between MCFRS's charges and the payor-"approved charges" are ordinarily not collectible. With regard to Medicare, this is considered to be "balance billing" and is prohibited by Medicare law. These mandatory "write offs" are referred to as "contractual allowances."

J. "Allowables"

For each payor category, we included an estimated "allowable" percentage. This can be confusing, but an "allowable" percentage is the percentage of the payor-approved charges that MCFRS can expect to be paid. In other words, once Medicare applies the "contractual allowance" referenced above and determines the "approved charge," Medicare only pays the provider 80% of that approved charge. The remaining 20% is a copayment, which is the responsibility of the patient. We conservatively assume in this model a copayment collection rate of zero.

We utilized a 100% "allowable" figure for Medicaid and commercial payors, but, again, remember that this is *not* the same as assuming a 100% "collection rate" from these

payors. This merely means, to use Medicaid as an example, that Medicaid can be expected to pay 100% of *its approved charge* for ambulance services (currently, $100) and *not* 100% of MCFRS's actual charges.

We utilized a collection rate of 10% for self-pay accounts, again reflecting the likely adoption of an "insurance only" billing policy for residents.

K. Patient Care Documentation

One key variable not reflected in these projections is that EMS billing is only as good as the field documentation that supports it. In an EMS system that has not previously billed for services, it can be expected that field personnel will not be sufficiently oriented to the importance of the documentation that is required from a revenue recovery perspective. Detailed documentation training will be required of all EMS personnel in the County to fully realize these revenue projections. Montgomery County policymakers and budget officials might want to take this factor into account when considering their anticipated EMS revenue budgets and reduce the projections by some estimated factor (for instance, 40% in Year One, 30% in Year Two, 20% in Year Three and 10% in Year Four) to account for this unpredictable variable.

III. Revenue Projections

A. Total Cash Receipts

We have broken down projected cash receipts by each payor, and then calculated an overall total. Year One revenues are projected at approximately $14 million. Years Two – Four projections are approximately $14.7 million, $15.4 million and $16.2 million, respectively. Again, County policymakers and budget officials must take into account the assumptions and limitations discussed above when budgeting anticipated revenues from the EMS transport fee program.

B. Average Revenue Per Transport

For each year, we project an Overall Projected Average Revenue Per Transport. This is a simple calculation of gross cash receipts divided by total transport volume in a given year. This takes into consideration all revenues from all payor sources and all levels of transport, but it is a helpful "global perspective" of billing performance.

It could be argued that the Average Revenue Per Transport estimates, which range from $247 in Year One to $253 in Year Four, are optimistic. Of course, this is directly related to the rate structure that the County's policymakers ultimately decide to put into place. Nevertheless, we have compared Montgomery County to other jurisdictions and believe there are some compelling reasons why these Average Revenue Per Transport estimates are reasonable.

First, Montgomery County has a comparatively high median household income. According to U.S. Census bureau statistics, Montgomery County median household income in 2004 was $76,957, compared with $57,019 for all of Maryland. This puts Montgomery County in the highest median household incomes in the United States. Given this statistic alone, some could argue that our Average Revenue Per Transport estimates are *too* conservative.

Second, we compared these Average Revenue Per Transport Estimates with other jurisdictions in the U.S. While these data does not always take into account the same factors, and thus creates a potential problem of comparing "apples and oranges," these data can be informative. For instance, in Dayton, Ohio (according to data obtained from that City's ambulance billing contractor), a city with a median household income of $34,978 and approximately 16,000 EMS transports per year, realized an average revenue per transport of $217. On the other side of the spectrum, Nassau County, New York, with a median household income ($80,647) comparable to Montgomery County's, and 42,106 annual transports, the average revenue per transport reported by their billing contractor is $380. We therefore believe that the Average Revenue Per Transport estimates in this revenue projection are realistic, again, depending upon the rate structure implemented by Montgomery County.

C. Gross and Net Collection Percentages

One common EMS billing measurement is the "collection percentage." Understanding your projected collection percentage is vital when evaluating the ongoing effectiveness of an outside billing contractor.

When measuring collection percentages, it is critical to distinguish the concepts of "gross" versus "net" collection percentages. Gross collections look at actual cash receipts divided by total charges. Net collections, on the other hand, look at actual cash receipts divided by the amount the provider is allowed to collect for the particular service, after the mandatory contractual allowances required by law are deducted. While both of these measurements of billing performance have their weaknesses, the use of a gross collections percentage as a measurement of billing performance is highly artificial.

Consider the following example. Say that an agency *charges* $600 for a BLS emergency call. Now, say that Medicare only *approves* $250 for a BLS emergency. Under the law, as discussed above, your agency must write off the difference between its charge and the Medicare approved amount. In this example, that "contractual allowance" would be $350. Under a gross collections approach, assuming you were fully paid by Medicare, and succeeded in collecting the 20% patient copayment (which likely would not be the case with Montgomery County residents), you would only have collected 41.7% - or $250/$600. However, under a net collections approach, your agency collected everything it was allowed to collect under the law, so your net collection percentage on this claim was 100%.

The gross vs. net collections approach – as shown in this example – illustrates how relatively easy it is to "manipulate" your "collection percentage" merely by adjusting your actual charges. For instance, say the ambulance service in our example above decides to increase its BLS emergency charge from $600 to $800. Now, its gross collection percentage on the sample claim drops to 31%, or $250/$800. The amount approved by Medicare doesn't increase merely because your charges increased, so the result is a drop in your gross collection percentage. However, the amount of cash you actually received stayed the same. So, on paper, your billing operation, when measured by a gross collection percentage, looks like its performance is getting worse, when actually it may be unchanged, or even better when you look at actual cash received. The reverse of this example is also a potential pitfall: lowering your charges would have the result of artificially *increasing* your net collection percentage, while not necessarily improving your cash receipts, thus perhaps making billing performance seem better than it is.

We projected both gross and net billing percentages for purposes of this report. The estimated gross collection rates are, conservatively, lower than reported national averages. For instance, the Jems 200 City Survey in 2007 reported that the average gross collection percentage for public-sector EMS agencies was 55.9%, Our gross collection percentage estimates run in the 47%-49% range.

It is likely that lower gross collection percentage estimates do result in higher *net* collection percentage estimates. This is because a lower *gross* percentage means that more of the "unallowed" charges have already been written off, leaving more "pure" and collectible revenue on the table. Therefore, one would expect that the *net* collection percentages would be higher. There are no meaningful, national net collection data reported of which we are aware. Nevertheless, again, because the net collection percentage represents income to which the County is legally and legitimately entitled, and already factors in the allowed amounts, contractual write offs and very low estimated self-pay percentage (10%), we believe that the net collection percentages represent realistic expectations for a billing contractor to achieve for a county as affluent as Montgomery County, Maryland.

IV. Conclusion

Though based on many variables that are subject to change, these EMS billing revenue projections demonstrate that there are substantial revenues that could be realized were Montgomery County to implement an EMS transport fee. Of course, the decision on whether or not to do so, and on how any realized revenues would be allocated, is up to the sound discretion of the County's policymakers.

V. Important Notices

These projections are estimates only and not a guarantee of financial performance. All projections are based in large part upon data supplied by the client. Estimating revenues from the provision of any health care services involves many variables that cannot be accounted for in a revenue estimate and that are beyond the control of the estimator. The consultants have stated all key assumptions and have provided a relational spreadsheet that allows the client to modify any assumptions that it finds necessary. The client is responsible to verify all assumptions that affect these projections and to modify them when necessary. This estimate does not constitute the rendering of professional accounting advice, and does not take any expenses into account. Revenue projections can also be impacted by changes in applicable reimbursement laws and regulations. The consultants are not responsible to update this analysis unless asked to do so by the client. Finally, the decision to undertake EMS billing rests entirely with the client, and the client bears all responsibility for appropriate and compliant billing operations.

Appendix A
Year One Revenue Projections

Montgomery County, MD EMS Transport Fee Revenue Projections Year One		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		56,977	22,791	2,279	15,954	15,954			
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**	
BLS-NE (A0428)	1%	$ 300	$ 210.85	228	$ 68,400	$ 48,074	80%	$ 38,459	
BLS-E (A0429)	42%	$ 400	$ 337.36	9,572	$ 3,828,800	$ 3,229,210	80%	$ 2,583,368	
ALS1-NE (A0426)	1%	$ 350	$ 253.02	2,281	$ 798,350	$ 577,139	80%	$ 461,711	
ALS1-E (A0427)	55%	$ 500	$ 400.61	12,535	$ 6,267,500	$ 5,021,646	80%	$ 4,017,317	
ALS2 (A0433)	1%	$ 700	$ 579.84	228	$ 159,600	$ 132,204	80%	$ 105,763	
SCT (A0434)	0%	$ 800	$ 685.27	-	$ -	$ -	80%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 6.42	113,955	$ 911,640	$ 731,591	80%	$ 585,273	
							TOTAL	$ 7,791,891	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**	
BLS-NE (A0428)	1%	$ 300	$ 100	23	$ 6,900	$ 2,300	100%	$ 2,300	
BLS-E (A0429)	42%	$ 400	$ 100	957	$ 382,800	$ 95,700	100%	$ 95,700	
ALS1-NE (A0426)	1%	$ 350	$ 100	23	$ 8,050	$ 2,300	100%	$ 2,300	
ALS1-E (A0427)	55%	$ 500	$ 100	1,253	$ 626,500	$ 125,300	100%	$ 125,300	
ALS2 (A0433)	1%	$ 700	$ 100	23	$ 16,100	$ 2,300	100%	$ 2,300	
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -	
							TOTAL	$ 227,900	
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**	
BLS-NE (A0428)	1%	$ 300	$ 200.10	160	$ 48,000	$ 32,016	100%	$ 32,016	
BLS-E (A0429)	42%	$ 400	$ 266.80	6,701	$ 2,680,400	$ 1,787,827	100%	$ 1,787,827	
ALS1-NE (A0426)	1%	$ 350	$ 233.45	160	$ 56,000	$ 37,352	100%	$ 37,352	
ALS1-E (A0427)	55%	$ 500	$ 333.50	8,774	$ 4,387,000	$ 2,926,129	100%	$ 2,926,129	
ALS2 (A0433)	1%	$ 700	$ 466.90	160	$ 112,000	$ 74,704	100%	$ 74,704	
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653	
							TOTAL	$ 5,283,681	

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 300	160		$ 47,861		10%	$ 4,786
BLS-E (A0429)	42%	$ 400	6,700		$ 2,680,198		10%	$ 268,020
ALS1-NE (A0426)	1%	$ 350	160		$ 55,837		10%	$ 5,584
ALS1-E (A0427)	55%	$ 500	8,774		$ 4,387,229		10%	$ 438,723
ALS2 (A0433)	1%	$ 700	160		$ 111,675		10%	$ 11,167
SCT (A0434)	0%	$ 800	-		$ -		10%	$
Loaded Miles (A0425) (Average/Trip)	5	$ 8	79,770		$ 638,160		10%	$ 63,816
							TOTAL	$ 792,096
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 29,008,320	$ 15,251,444		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR ONE	**$ 14,095,567**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 247**
GROSS COLLECTION PERCENTAGE	**49%**
NET COLLECTION PERCENTAGE	**92%**

Notes and Assumptions:

Transport volume is based on estimates provided by Montgomery County Fire Rescue

Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions

Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay

2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008

Revenue model assumes annual increases in charges of 5%

ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants

Assumes complete documentation necessary to support billing decisions; crew documentation training recommended

Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents

Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix B
Year Two Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Two		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)		
		59,256	23,702	2,370	16,592	16,592		

Payor: Medicare (40%)	Est. % of Transports	Charge	Medicare Approved Charge	Est. Medicare Transport Volume	Total Charges	Total Medicare Approved Charges	Medicare Allowable	Total Medicare Cash Receipts
BLS-NE (A0428)	1%	$ 315	$ 216.12	228	$ 71,820	$ 49,275	80%	$ 39,420
BLS-E (A0429)	42%	$ 420	$ 345.79	9,572	$ 4,020,240	$ 3,309,902	80%	$ 2,647,922
ALS1-NE (A0426)	1%	$ 368	$ 259.35	2,281	$ 838,268	$ 591,577	80%	$ 473,262
ALS1-E (A0427)	55%	$ 525	$ 410.63	12,535	$ 6,580,875	$ 5,147,247	80%	$ 4,117,798
ALS2 (A0433)	1%	$ 735	$ 594.34	228	$ 167,580	$ 135,510	80%	$ 108,408
SCT (A0434)	0%	$ 840	$ 702.40	-	$ -	$ -	80%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ 6.58	113,955	$ 957,222	$ 749,824	80%	$ 599,859
							TOTAL	$ 7,986,668

Payor: Medicaid (4%)	Est. % of Transports	Charges	Medicaid Approved Charge	Est. Medicaid Transport Volume	Total Charges	Total Medicaid Approved Charges	Medicaid Allowable	Total Medicaid Cash Receipts
BLS-NE (A0428)	1%	$ 315	$ 100	23	$ 7,245	$ 2,300	100%	$ 2,300
BLS-E (A0429)	42%	$ 420	$ 100	957	$ 401,940	$ 95,700	100%	$ 95,700
ALS1-NE (A0426)	1%	$ 368	$ 100	23	$ 8,453	$ 2,300	100%	$ 2,300
ALS1-E (A0427)	55%	$ 525	$ 100	1,253	$ 657,825	$ 125,300	100%	$ 125,300
ALS2 (A0433)	1%	$ 735	$ 100	23	$ 16,905	$ 2,300	100%	$ 2,300
SCT (A0434)	0%	$ 840	$ 100	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ -	11,395	$ 95,718	$ -	0%	$ -
							TOTAL	$ 227,900

Payor: Commercial/Auto (28%)	Est. % of Transports	Charges	Est. Ins. Approved Charge	Est. Commercial/Auto Volume	Total Charges	Total Insurance Approved Charges	Insurance Allowable	Total Insurance Cash Receipts
BLS-NE (A0428)	1%	$ 315	$ 215.36	160	$ 50,400	$ 34,457	100%	$ 34,457
BLS-E (A0429)	42%	$ 420	$ 287.14	6,701	$ 2,814,420	$ 1,924,149	100%	$ 1,924,149
ALS1-NE (A0426)	1%	$ 368	$ 251.25	160	$ 58,800	$ 40,200	100%	$ 40,200
ALS1-E (A0427)	55%	$ 525	$ 358.93	8,774	$ 4,606,350	$ 3,149,246	100%	$ 3,149,246
ALS2 (A0433)	1%	$ 735	$ 502.50	160	$ 117,600	$ 80,400	100%	$ 80,400
SCT (A0434)	0%	$ 840	$ 574.29	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ 5.74	79,770	$ 670,068	$ 458,109	100%	$ 458,109
							TOTAL	$ 6,686,661

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 315	166		$ 52,264		10%	$ 5,226
BLS-E (A0429)	42%	$ 420	6,969		$ 2,926,772		10%	$ 292,677
ALS1-NE (A0426)	1%	$ 368	166		$ 60,974		10%	$ 6,097
ALS1-E (A0427)	55%	$ 525	9,125		$ 4,790,848		10%	$ 479,085
ALS2 (A0433)	1%	$ 735	166		$ 121,949		10%	$ 12,195
SCT (A0434)	0%	$ 840	-		$ -		10%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	79,770		$ 670,068		10%	$ 67,007
							TOTAL	$ 862,288
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 30,764,603	$ 15,897,796		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR TWO	**$ 14,763,417**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 249**
GROSS COLLECTION PERCENTAGE	**48%**
NET COLLECTION PERCENTAGE	**93%**

Notes and Assumptions:

- Transport volume is based on estimates provided by Montgomery County Fire Rescue
- Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions
- Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay
- 2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008
- Revenue model assumes annual increases in charges of 5%
- ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants
- Assumes complete documentation necessary to support billing decisions; crew documentation training recommended
- Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents
- Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix C
Year Three Revenue Projections

Montgomery County, MD
EMS Transport Fee - Revenue Projections
Year Three

Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)
61,626	24,650	2,465	17,255	17,255

Payor: Medicare (40%)	Est. % of Transports	Charge	Medicare Approved Charge	Est. Medicare Transport Volume	Total Charges	Total Medicare Approved Charges	Medicare Allowable	Total Medicare Cash Receipts
BLS-NE (A0428)	1%	$ 331	$ 221.52	228	$ 75,468	$ 50,507	80%	$ 40,406
BLS-E (A0429)	42%	$ 441	$ 354.43	9,572	$ 4,221,252	$ 3,392,604	80%	$ 2,714,083
ALS1-NE (A0426)	1%	$ 386	$ 265.83	2,281	$ 880,466	$ 606,358	80%	$ 485,087
ALS1-E (A0427)	55%	$ 551	$ 420.90	12,535	$ 6,906,785	$ 5,275,982	80%	$ 4,220,785
ALS2 (A0433)	1%	$ 772	$ 609.20	228	$ 176,016	$ 138,898	80%	$ 111,118
SCT (A0434)	0%	$ 882	$ 719.96	-	$ -	$ -	80%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.82	$ 6.74	113,955	$ 1,005,083	$ 768,057	80%	$ 614,445
							TOTAL	$ 8,185,924

Payor: Medicaid (4%)	Est. % of Transports	Charges	Medicaid Approved Charge	Est. Medicaid Transport Volume	Total Charges	Total Medicaid Approved Charges	Medicaid Allowable	Total Medicaid Cash Receipts
BLS-NE (A0428)	1%	$ 331	$ 100	23	$ 7,613	$ 2,300	100%	$ 2,300
BLS-E (A0429)	42%	$ 441	$ 100	957	$ 422,037	$ 95,700	100%	$ 95,700
ALS1-NE (A0426)	1%	$ 386	$ 100	23	$ 8,878	$ 2,300	100%	$ 2,300
ALS1-E (A0427)	55%	$ 551	$ 100	1,253	$ 690,403	$ 125,300	100%	$ 125,300
ALS2 (A0433)	1%	$ 772	$ 100	23	$ 17,756	$ 2,300	100%	$ 2,300
SCT (A0434)	0%	$ 882	$ 100	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.82	$ -	11,395	$ 100,504	$ -	0%	$ -
							TOTAL	$ 227,900

Payor: Commercial/Auto (28%)	Est. % of Transports	Charges	Est. Ins. Approved Charge	Est. Commercial/Auto Volume	Total Charges	Total Insurance Approved Charges	Insurance Allowable	Total Insurance Cash Receipts
BLS-NE (A0428)	1%	$ 331	$ 231.95	160	$ 52,960	$ 37,113	100%	$ 37,113
BLS-E (A0429)	42%	$ 441	$ 309.04	6,701	$ 2,955,141	$ 2,070,865	100%	$ 2,070,865
ALS1-NE (A0426)	1%	$ 386	$ 270.50	160	$ 61,760	$ 43,279	100%	$ 43,279
ALS1-E (A0427)	55%	$ 551	$ 386.12	8,774	$ 4,834,474	$ 3,387,839	100%	$ 3,387,839
ALS2 (A0433)	1%	$ 772	$ 540.99	160	$ 123,520	$ 86,559	100%	$ 86,559
SCT (A0434)	0%	$ 882	$ 618.08	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.82	$ 6.18	79,770	$ 703,571	$ 493,040	100%	$ 493,040
							TOTAL	$ 6,118,694

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 331	173		$ 57,115		10%	$ 5,711
BLS-E (A0429)	42%	$ 441	7,247		$ 3,196,023		10%	$ 319,602
ALS1-NE (A0426)	1%	$ 386	173		$ 66,605		10%	$ 6,661
ALS1-E (A0427)	55%	$ 551	9,490		$ 5,229,213		10%	$ 522,921
ALS2 (A0433)	1%	$ 772	173		$ 133,211		10%	$ 13,321
SCT (A0434)	0%	$ 882	-		$ -		10%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.82	79,770		$ 703,571		10%	$ 70,357
							TOTAL	$ 938,574
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 32,629,425	$ 16,578,999		

GRAND TOTAL - *PROJECTED CASH RECEIPTS - YEAR THREE*	**$ 15,471,092**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 251**
GROSS COLLECTION PERCENTAGE	**47%**
NET COLLECTION PERCENTAGE	**93%**

Notes and Assumptions:

- Transport volume is based on estimates provided by Montgomery County Fire Rescue
- Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions
- Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay
- 2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008
- Revenue model assumes annual increases in charges of 5%
- ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants
- Assumes complete documentation necessary to support billing decisions; crew documentation training recommended
- Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents
- Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix D
Year Four Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Four		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		64,091	25,636	2,564	17,945	17,945			
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 227.06	228	$ 79,241	$ 51,770	80%	$ 41,416	
BLS-E (A0429)	42%	$ 463	$ 363.29	9,572	$ 4,432,315	$ 3,477,412	80%	$ 2,781,930	
ALS1-NE (A0426)	1%	$ 405	$ 272.48	2,281	$ 923,805	$ 621,527	80%	$ 497,222	
ALS1-E (A0427)	55%	$ 579	$ 431.42	12,535	$ 7,252,124	$ 5,407,850	80%	$ 4,326,280	
ALS2 (A0433)	1%	$ 811	$ 624.43	228	$ 184,817	$ 142,370	80%	$ 113,896	
SCT (A0434)	0%	$ 926	$ 737.96	-	$ -	$ -	80%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ 6.91	113,955	$ 1,055,223	$ 787,429	80%	$ 629,943	
							TOTAL	$ 8,390,686	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 100	23	$ 7,994	$ 2,300	100%	$ 2,300	
BLS-E (A0429)	42%	$ 463	$ 100	957	$ 443,139	$ 95,700	100%	$ 95,700	
ALS1-NE (A0426)	1%	$ 405	$ 100	23	$ 9,315	$ 2,300	100%	$ 2,300	
ALS1-E (A0427)	55%	$ 579	$ 100	1,253	$ 724,923	$ 125,300	100%	$ 125,300	
ALS2 (A0433)	1%	$ 811	$ 100	23	$ 18,644	$ 2,300	100%	$ 2,300	
SCT (A0434)	0%	$ 926	$ 100	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ -	11,395	$ 105,518	$ -	0%	$ -	
							TOTAL	$ 227,900	
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 249.64	160	$ 55,608	$ 39,942	100%	$ 39,942	
BLS-E (A0429)	42%	$ 463	$ 332.60	6,701	$ 3,102,898	$ 2,228,768	100%	$ 2,228,768	
ALS1-NE (A0426)	1%	$ 405	$ 290.91	160	$ 64,800	$ 46,545	100%	$ 46,545	
ALS1-E (A0427)	55%	$ 579	$ 415.56	8,774	$ 5,076,198	$ 3,646,162	100%	$ 3,646,162	
ALS2 (A0433)	1%	$ 811	$ 582.24	160	$ 129,696	$ 93,159	100%	$ 93,159	
SCT (A0434)	0%	$ 926	$ 665.20	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ 6.65	79,770	$ 738,670	$ 530,576	100%	$ 530,576	
							TOTAL	$ 6,585,153	

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 348	179		$ 62,370		10%	$ 6,237
BLS-E (A0429)	42%	$ 463	7,537		$ 3,490,055		10%	$ 349,005
ALS1-NE (A0426)	1%	$ 405	179		$ 72,679		10%	$ 7,268
ALS1-E (A0427)	55%	$ 579	9,870		$ 5,710,297		10%	$ 571,030
ALS2 (A0433)	1%	$ 811	179		$ 145,466		10%	$ 14,547
SCT (A0434)	0%	$ 926	-		$ -		10%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	79,770		$ 738,670		10%	$ 73,867
							TOTAL	$ 1,021,954
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 34,624,464	$ 17,301,410		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR FOUR	**$ 16,225,692**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 253**
GROSS COLLECTION PERCENTAGE	**47%**
NET COLLECTION PERCENTAGE	**94%**

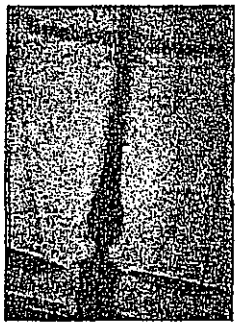
Notes and Assumptions:

- Transport volume is based on estimates provided by Montgomery County Fire Rescue
- Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions
- Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay
- 2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008
- Revenue model assumes annual increases in charges of 5%
- ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants
- Assumes complete documentation necessary to support billing decisions; crew documentation training recommended
- Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents
- Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix E
EMS Rate Setting Article



LEGAL CONSULT

INCISIVE ANALYSIS OF EMS LEGAL TOPICS

How Should Your Ambulance Service Set Its Rates?

If your EMS organization charges for its services, you probably spend days, weeks or months learning all the complex rules about billing. But if you ask administrators how they set their rates, many will provide an answer that is only slightly more advanced than "We pull them out of thin air." However, whether your service is public, private or not-for-profit, proper rates are crucial to your organization's overall success, and a rate-setting strategy that complies with the law is fundamental.

First and foremost, start by taking accurate measure of your organization's costs. This includes an assessment not only of such big-ticket line items as personnel, vehicles, equipment and insurance, but also an assessment of fuel, maintenance, heat, electricity and all other overhead elements. Don't forget depreciation; part of your revenues must go toward replacing capital assets in the future as well as to support current operations. These costs must be amortized—or spread over your expected call volume—and must allow for the possibility of bad debt or uncollectible accounts, so your rates reflect the true costs of doing business.

Next, consider whether your organization operates in a rate-regulated environment. While only a small handful of states (e.g., Arizona, Utah and Connecticut) regulate rates at the state level, some local governments may establish ordinances or laws that set ambulance rates or establish maximum fee schedules. Even if your locality has no such local law or ordinance, some contracts between ambulance services and the areas they serve include rate stipulations, so be sure to consult your municipal contracts for any applicable rate restrictions.

An ambulance service that is not rate-regulated generally has a significant degree of flexibility in setting its rates. In fact, your organization can price its services as it sees fit and can generally raise those rates at any time.

Of course, not every payer will reimburse you for 100% of your bill, so you must also factor these mandatory write-offs (called contractual allowances) into your rate-setting. Medicare, for instance, will only pay amounts approved under the Ambulance Fee Schedule, and the patient cannot be "balance billed" for anything above that approved amount (except for his or her deductible—if applicable—or co-payment). So you must write off the difference between your rates and the Medicare fee-schedule rates.

Knowing these contractual allowance amounts will prove critical in measuring your billing performance. Many EMS organizations focus on calculating collection percentages, but be sure you measure performance consistently. Gross collection percentages measure the amount collected versus the total amounts billed. Net collection percentages—which generally provide a more meaningful measurement of billing performance—evaluate the total amount collected versus the total amounts billed, minus the contractual allowances that the law requires you to write off.

Another fundamental decision your organization must make with regard to rates is whether it will bill for services on a bundled or an unbundled basis. A service using bundled billing rolls all charges for supplies, services, etc., into one base rate charge (typically billing only mileage separately). A service that uses unbundled billing may charge separately for such things as oxygen, disposable supplies, wait time and extra attendants.

Though Medicare no longer pays on an unbundled basis and considers all these ancillary charges to be part of the provider's base rate, other payers may still recognize these separate charges. So your service should consider the ramifications of charging those payers on a bundled versus unbundled basis before deciding how to bill them.

Important: Remember when setting your rates that Medicare will pay only the lesser of either the approved fee schedule amount or the amount you bill. In other words, if you charge less than the Medicare-approved amount, Medicare will pay only up to the amount of your bill. For that reason, and because Medicare is the single largest payer for most ambulance services, you should ensure that your rates are higher than the Medicare-approved amounts for your various levels of service; otherwise, your agency leaves legitimate revenue on the table.

Many EMS administrators mistakenly believe that an ambulance service must charge all payers the exact same rates. This

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generally is not the case, however. Ambulance services often charge different rates in different circumstances.

For instance, if your organization participates in a managed care network as a contracted provider, you might have a rate schedule in your agreement with a particular HMO or health plan that is lower than your retail rate schedule. In some cases, rates charged to a facility, such as a hospital or nursing home, also may differ from your agency's retail rates.

Another important reminder: Although providers generally may charge different rates under various circumstances, remember that your rates must comply with such laws as the federal anti-kickback statute.

For example, if you discount the rates you charge a facility, it could appear that those discounts were given in exchange for the facility's referral of Medicare patients to your service, which could constitute an illegal inducement and give rise to a violation of the AKS. (Much has been written about the AKS and its application to ambulance services in the pages of the *EMS Insider* in recent years.)

A final caveat: Setting your rates should not be a group exercise. In other words, to avoid raising issues under state or federal antitrust laws, your organization must not establish its rates based on discussions or agreements with your competitors or with other services in your area. This kind of conduct could be seen as price fixing and can have serious legal consequences.

Although you will need to consider other issues when setting rates, these are the primary considerations. Within the broad parameters of state and federal laws, most ambulance services have great flexibility in establishing rates and charges for their services.

Your organization will be best served if you give your rates the thought and attention they deserve instead of merely pulling them out of thin air.

Although providers generally may charge different rates under various circumstances, remember that your rates must comply with such laws as the federal anti-kickback statute.

Help OSHA Revise Its Emergency-Response Regulations

The Occupational Safety and Health Administration currently covers emergency responder safety as part of several standards, some of which are decades old and out of date. Consequently, OSHA is working to develop a single, unified set of revised regulations, and is soliciting input from the emergency-response community by May 1 on what the revised regulations should include.

For more information and/or to contribute to this effort, visit www.dol.gov/osha/regs/unifiedagenda/2127.htm.

Wait to Respond to AMR, IAFC Advises Fire Departments

The International Association of Fire Chiefs on Jan. 4 asked fire departments to hold off on responding to an American Medical Response solicitation to EMS providers nationwide to agree to provide ambulance services during large-scale disasters "until the IAFC and the Federal Emergency Management Agency can identify if the fire service can fill the potential need." According to IAFC, FEMA "has placed a hold on this initiative until it can review the work and recommendations of the [IAFC] Mutual Aid System Task force." IAFC predicted that the association and FEMA would be able to "resolve this issue and provide additional guidance by February 2007."

For more information, visit www.iafc. org or contact Lucian Deaton, IAFC EMS manager/govern mental relations at ldeaton@iafc.org.

OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett
County Executive

Joseph F. Beach
Director

MEMORANDUM

July 23, 2008

TO: Minna Davidson, County Council Staff

FROM: Joseph Beach, Director
Office of Management and Budget

SUBJECT: Bill 25-08, Emergency Medical Services Transport Fee –Imposition Fiscal Impact

Please find below the responses to your questions concerning the fiscal impact of the subject legislation. Please contact me at 7-2777 if you have additional questions or concerns.

Assumptions for Revenues and Fees

1. Please list the number and type of EMS calls for service and transports in each fee category over the past 3 years.

	FY2005	FY2006	FY2007
Calls for Service			
ALS	30,379	30,918	31,901
BLS	43,597	43,475	44,961
Total Calls for Service	73,976	74,393	76,862
Transports			
ALS In County	23,954	24,959	26,579
BLS In County	26,744	27,653	28,981
Total In County Transports	50,698	52,612	55,560

ALS Out of County and Federal	509	535	620
BLS Out of County and Federal	593	781	1,105
Total Out of County Transports	1,102	1,316	1,725
Total Transports	51,800	53,928	57,285

2. What was the basis for the increases in EMS transport volume that were assumed in years 2 to 4 in the revenue estimate?

   Keeping in mind that accurate "year one" baseline data is based upon the current paper-based reporting system, making transport volume estimates less reliable than if they were based upon electronic data, the transport volume estimates for years 2-4 were established with the assumption that transport volume would increase by 4% per year. We believe this estimate to be reasonable based upon population growth, historic growth in transport volumes, and other demographic changes. As the table above indicates, the average growth in transports over the past three years has been over 5%.

3. How did Page, Wolfberg, Wirth determine the breakout of payor types: Medicare 40%; Medicaid 4%; Commercial/Auto 28%; Self-Pay 28%?

   These payor mix estimates were partially based on the "2006 JEMS 200 City Survey" published in February, 2007 by the Journal of Emergency Medical Services. However, the payor mix estimates in that study were adjusted to reflect what we believe is a more accurate reflection of the demographics of Montgomery County.

4. How was the proposed fee structure chosen? What alternatives were considered?

   Because, under Federal law, Medicare will only reimburse an ambulance provider the lesser of the provider's charges, or the approved Medicare fee schedule amounts, we utilized Medicare's approved base rates as a starting point in order to avoid a differential between the approved rates and the County's charges. However, the cost of MCFRS providing EMS services far exceeds the revenues generated by the proposed fees. In addition, please note that under the revenue estimate model, more than 94% of the projected revenues derive from insurers; less than 6% of revenues are forecasted to come from (out of County) patients.

Field Documentation

5. The Page, Wolfberg, Wirth report (p. 7) says that EMS billing is only as good as the field documentation that supports it, and that detailed training will be needed to fully realize revenue projections.

   a. How much training per staff member will be needed?

      MCFRS personnel will receive 4 hours of patient care documentation training with the new electronic patient care reporting (e-PCR) program. Currently, all new recruits receive 8 hours of dedicated patient care documentation training in recruit school. EMT-B students receive 4 hours of initial training.

   b. Who will provide the training?

      This is currently done by a local contractor as well as in house instructors.

   c. What will the training cost? Is that cost included in the fiscal impact statement?

      The cost is built into the e-PCR plan. It will consist of 4 hours on-duty in service training.

   d. How will the training be provided – on straight time or overtime? Will the training result in any cost to backfill positions?
      The instructors will be a small cadre consisting of existing administrative EMS personnel. The training will be conducted on-duty, straight time by existing EMS administrative, training, and operations staff.

6. The report also suggests reducing revenue projections by an estimated factor to account for initial limits in field documentation collection (for example, 40% in Year 1, 30% in Year 2, 20% in Year 3, and 10% in Year 4).

   a. If the County implements an automated field documentation collection system, what are the likely rates of incomplete data collection or errors?

      While, the error rates can be expected to be lower with the implementation of an electronic PCR system as opposed to a paper-based PCR system, the specific amount of this variance is not known and it would be too speculative to quantify.

   b. What has been the initial experience with field documentation in other jurisdictions? Has their field documentation start-up resulted in decreased revenue collections similar to the examples in the report?

      It is important to bear in mind that the providers in Montgomery County do currently document the care they provide; however, there are additional issues that need to be addressed for documentation to be capable of supporting reimbursement. We do not have any data with regard to revenues before and after e-PCR implementation in

other jurisdictions, however, both accuracy and cash flow (due to reduced trip-to-bill time) would both be expected to increase with e-PCR implementation.

Implementation Resources

7. Why are 6 new positions needed to implement the EMS fee? Please explain what each position would do.

The initial estimate from the MCFRS was that six positions would be needed to adequately manage the successful implementation of this program. However, the County Executive's Recommended budget included funding for only two of these positions: the Manager of Billing Services and the IT Specialist for Hardware. The Billing Manager is needed to manage the contract with the third party vendor, and serve as a liaison with insurance companies, other departments supporting program implementation (e.g. Public Information, Department of Finance, etc), and the public. The IT Specialist is needed to implement the e-PCR system. This will be a major new system for MCFRS and County Government and dedicated support will be needed to ensure its successful implementation into MCFRS operations, appropriate functioning to support the EMST billing program, and that it will integrate into the County's IT architecture. This position is critical to the success of the field responders guaranteeing that the hardware and software required to capture all patient care information is ready 24/7.

The County Executive was withholding a decision on the remaining positions pending the first year of experience in implementing the program. However it was envisioned that the following positions would perform the functions stated:
Office Service Coordinator: an OSC is required to process the day to day administrative needs of the section.

IT Specialist – Data Analyst: This position will manage data, queries, quality assurance, and system performance. While this position will work primarily with the revenue recovery aspect, the data analyst will work with the training, operations, and EMS field quality assurance sections to improve provider performance as well as identify injury and illness trends within the community allowing MCFRS to program education towards preventing the 911 call.

Quality Compliance (2) – These two positions will provide oversight to the field providers relating to patient care documentation, completion of e-PCR materials, as well as previously mentioned system performance input.

8. If a third party vendor is hired to administer the fee, why would 2 County IT positions be necessary?

The 2 IT positions would primarily be for implementing, supporting, and using the e-PCR system. The third party vendor would use the information from this system, but would have not other role in managing the e-PCR system; therefore, additional IT support is needed. However, whether two additional positions are necessary or both positions should be part of the Information Technology Occupational Series will need to be determined in the future

after the EMST program is initiated and there is sufficient experience in administering this program.

9. Where would office space for the positions be located? Would additional rental space be needed?

The positions would be located in the existing office space at 701 Dover Road. Space at the Dover Road Facility that is currently being used by Apparatus management staff will be vacated as that staff relocates later in this fiscal year to the Southlawn Maintenance facility. No additional rental space will be needed.

10. What is the basis for the assumption that a third party vendor would cost 5% of revenues? What is the experience in other jurisdictions in the area?

The assumption that a third party vendor would provide this service at 5% is based on the fact that the third party vendor for Fairfax County provides this service at a fee of 5.5%. Experience in other jurisdictions vary depending on the contractual arrangements, but the Fairfax County contract is the lowest amount based on our research.

11. What is involved in hiring a third party vendor? How long would the procurement process take?

A third party vendor could be procured either through: 1) a Request for Proposal (RFP) which would take approximately 6 months; or 2) bridging the competitively procured contract of another jurisdiction which would take approximately 4 to 6 weeks.

12. The new Electronic Patient Care Reporting (E-PCR) system is needed to comply with State requirements for electronic reporting by the end of 2008. What arrangements are being made to acquire the system?

MCFRS has issued a Request for Expression of Interest (REOI), conducted vendor demonstrations, and is in the process of conducting reference inquiries. The Department of Technology Services is in the process of reviewing the technical merits and related technical issues related to implementing this system in the County's IT architecture. After the technical review is completed we will shortly request a supplemental appropriation to fund the acquisition of this system.

13. How would the EPCR system relate to the third party billing process?

An e-PCR system relates to the billing process in many ways. First, the crew's clinical and operational documentation from the Patient Care Report (PCR) is the primary source of information for determining the proper charge, procedure codes, modifiers, mileage and other factors necessary for the generation of the bill. Second, presuming that the e-PCR software is compatible with the billing software, an e-PCR system decreases the time interval from completion of the transport to preparation of the invoice ("trip-to-bill time"), due to

elimination of the need for data entry personnel to manually key the PCR information into the billing software. Third, electronic interface between the e-PCR data and the billing software eliminates the possibility of transcription error between the author of the PCR and the data entry clerk who enters it into the billing software. Fourth, the e-PCR system facilitates internal reviews of the billing process, so that the County can monitor the performance of its billing vendor, audit claims, audit provider documentation, and more. Of course, the primary purposes of an e-PCR system are to facilitate documentation of clinical patient care, quality improvement, case review and other clinical and operational functions, but the benefits of an e-PCR system in the billing process are numerous.

copies:
Tom Carr, Fire Chief
Kathleen Boucher, Assistant Chief Administrative Officer
Scott Graham, Assistant Chief
Blaise Defazio, OMB Analyst

OFFICES OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

June 23, 2008

TO: Minna Davidson, Senior Legislative Analyst

FROM: Kathleen Boucher, Assistant Chief Administrative Officer

RE: Public Safety Committee's June 26th Worksession on Bill 25-08, Emergency Medical Services Transport Fee – Imposition

I am forwarding a document entitled *Emergency Medical Services Transport Fee: Recommended Process, Rates, and Uses* ("EMST Fee Overview Presentation"), which will be presented to the Public Safety Committee at its June 26th worksession on Bill 25-08, Emergency Medical Services Transport Fee - Imposition. I am also enclosing the following background materials relating to the EMST Fee: (1) an informational brochure prepared by the Office of Public Information; (2) a list of Frequently Asked Questions; and (3) a notice of the town hall meetings being held at senior centers in June.

The following is a response to your questions regarding the County Executive's EMST Fee proposal. This memorandum restates each of your questions and then sets out the Executive's response.

Bill 25-08

1. *Why does Section 21-23A (b) say that MCFRS **must** impose a fee? Why not **may**?*

Answer: The word "must" is used to reflect the intent of the bill, which is to require MCFRS to impose an EMST fee on emergency medical service transports. If the Council would like to amend the bill to use the word "may" to provide flexibility in the future, the Executive has no objection.

2. *In the same section, who should be authorized to impose the fee – MCFRS or the Executive? (Section 21-23A(h) says that the Executive must issue an implementing regulation.)*

Answer: Section 21-23A(b) requires MCFRS to impose the fee because MCFRS would be the Executive branch department that implements the EMST fee. If Council would like to amend the bill to require the Executive to impose the fee, the Executive has no objection. The practical result would be the same.

3. *Does the language in Section 21-23A(c) mean that an uninsured County resident will not be billed?*

Answer: Yes.

4. *What is the liability for payment for individuals who work in the County, but do not live here?*

Answer: A patient who works in the County but does not reside in the County would be treated the same as any other patient who does not reside in the County. An insured patient who does not reside in the County will receive a bill for any applicable co-pay or deductible. A Request for Waiver form will be included with the bill. An uninsured patient who does not reside in the County will receive a bill for the EMST service. A Request for Waiver form will be included with the bill.

5. *Why were the federal poverty guidelines selected as the standard for hardship? Could a multiple of the federal poverty guidelines be used instead, as in certain County health and human services programs?*

Answer: The Executive believes that a means test should be used to determine whether a patient is eligible for a waiver of the EMST fee. The federal poverty guidelines, or multiples of them, are used as a means test for numerous federal, State, and County programs. The Executive is open to discussing whether a multiple of the federal poverty guidelines would be the appropriate criterion for a waiver.

6. *Does the law have to specify the threshold for a hardship waiver, or could it be specified by regulation?*

Answer: The criterion for a waiver could be specified in either the County Code or Executive Regulations. The Executive recommends that it be specified in regulations.

7. *What happens to someone who is over the threshold for a hardship waiver, but is unable to pay an EMST bill?*

Answer: Fee waivers are applicable only to patients who are not County residents. A County resident is responsible for the EMST fee only to the extent of insurance coverage so fee waivers will not be needed by County residents. An insured patient who is not a County resident will receive a bill for any applicable co-pay or deductible. If the patient is not eligible for a waiver, the patient is responsible for the co-

pay or deductible. An uninsured patient who is not a County resident will receive a bill for the EMST service. If the patient is not eligible for a waiver, the patient is responsible for payment.

8. *Why is there a requirement for fee revenues to supplement, but not supplant, existing expenditures for EMS and related MCFRS services?*

Answer: The primary reason that the EMST fee is needed is to provide additional resources for urgently needed enhancements to MCFRS. It would not serve the purpose of instituting the fee if it merely supplanted existing resources levels.

9. *What provisions will be made for the LFRDs to receive a portion of the EMST fee revenue? Should the law require the provisions to be included in the implementing regulation?*

Answer: Our efforts to study the feasibility and impacts of implementing an EMST Fee have included discussions with the LFRDs and the Montgomery County Volunteer Fire and Rescue Association (MCVFRA). The primary concerns of the LFRDs appear to be that the EMST Fee would deter some residents from calling for emergency services and that the existence of the fee may impair their fund raising efforts.

We have found no evidence to support the claim that calls for emergency service or patient transports decline after the imposition of an EMST Fee. Similarly, we have found no evidence that EMST Fees impair the fund raising efforts of volunteer fire corporations. The County's policies and budgetary decisions should be driven by data, evidence, and best practices and not by assertions lacking any factual basis.

We have discussed with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents as well as to offset any reduction in fund raising that may be caused by the imposition of an EMST Fee.

The Executive published notice of a proposed Executive Regulation to implement an EMST Fee in the June 2008 County Register. That notice included the following statement:

> "An amendment will be considered to establish a process or formula to distribute a portion of the revenue received from the EMS fee to the Local Fire and Rescue Departments. Comment is invited on an appropriate process or formula for distributing revenue from the EMS fee to the Local Fire and Rescue Departments."

The Executive intends to recommend a process and formula for distributing revenues from the EMST Fee to the LFRDs after the public comment period on the proposed Executive Regulation closes on July 1, 2008.

Regulation

1. *Section 2(a): What kind of financial information would the Fire Chief require that would be necessary for the collection of the fee?*

Answer: The Fire Chief will need to obtain financial information from patients who request fee waivers in order to determine eligibility for a waiver.

2. *Section 2(b): This section requires each insured individual to execute an assignment of benefits form. What happens to an uninsured individual?*

Answer: A County resident is responsible for the EMST fee only to the extent of insurance coverage. An uninsured patient who is a County resident may receive a request for information to confirm lack of insurance coverage. An uninsured patient who is not a County resident will receive a bill for the EMST service. If the patient is not eligible for a waiver, the patient is responsible for payment.

3. *Section 2(d): The Fire Chief **must** increase the fees annually... Why not **may**?*

Answer: Section 2.c provides that the Fire Chief must increase the amount of the fees in the schedule annually by the amount of the Ambulance Inflation Factor (AIF) as published by the Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services. The word "must" is used to reflect the intent of the regulation, which is to require that an inflation adjustment occur annually. If the Council believes that the regulation should use the word "may" to provide flexibility in the future, the Executive has no objection.

4. *The regulation includes the fee schedule and provisions for the collection of information, but it does not spell out how the fee collection process would work for an individual who receives an EMS transport. Where would that information be provided?*

Answer: The EMST Fee Overview Presentation (pages 6, and 10-11) includes a description of the primary components of the fee collection process. We do not believe that the details of the fee collection process should be included in Bill 25-08 or Executive Regulations implementing the bill because all of the relevant details of this process will not be known until the County executes a contract with a billing vendor.

5. *Should any rules about the collection process be included in the regulation?*

Answer: See answer to question 4.

Implementation Plan

1. *Please explain what collection activities an individual who receives an EMS transport would experience while they are being transported, at the hospital, and afterwards.*

Answer: The EMST Fee Overview Presentation (see pages 10-11) includes a flow chart which describes the primary components of the fee collection process during transport, at the hospital, and afterwards.

2. *If the Council approved the fee, what would be the timeframe for implementation?*

Answer: Implementing the EMST Fee will consist of 2 primary components: (1) hiring the additional full-time MCFRS personnel outlined in the fiscal impact statement for Bill 25-08; and (2) retaining a third party billing vendor to collect the fee. The timeframe for the former is 3-5 months, which includes the time necessary to prepare position descriptions, advertise, and fill the positions. The timeframe for the latter depends on whether the County bridges an existing contract or seeks a new contract through the RFP process. If the County bridges an existing contract, a billing vendor could likely be obtained within 3 months. If the County uses the RFP process, a bill vendor could likely be obtained within 6 months.

3. *What would be the timeframe for rolling out the public outreach?*

Answer: The Executive has already initiated a community outreach campaign to educate the public about the potential implementation of an EMST Fee in the County, including distribution of informational brochures and meetings with senior citizens, the County's 5 citizen advisory boards, and the MCVFRA. The EMST Fee Overview Presentation (page 6) includes an outline of the components of a comprehensive community outreach campaign that will be implemented after Bill 25-08 is enacted.

4. *When would decisions be made regarding the LFRD allocation?*

Answer: See Answer to Question 9 under the subheading "Bill 25-08".

5. *What IT resources would be needed for the implementation of the fee? How long would it take to obtain them? How much training would MCFRS staff or others need in order to use them?*

Answer: The primary IT resource needed to implement that EMST Fee is the Electronic Patient Care Reporting (e-PCR) System. Currently, MCFRS uses paper reporting. The Maryland Institute for Emergency Medical Services Systems previously announced that it will discontinue paper reporting on December 31, 2008. MCFRS must move quickly to implement the e-PCR system to comply with that deadline, as well as to prepare for implementing an EMST Fee. MCFRS personnel would need to receive training on the e-PCR system as well as HIPAA requirements. In addition, in the first year of implementation of the system MCFRS will require an IT Specialist to manage IT

issues related to the EMST fee including the e-PCR. In the second year of implementation an IT Specialist will be required for supporting the management of the data in the e-PCR.

Attachments (4)

cc:
Timothy L. Firestine, Chief Administrative Officer
Thomas Carr, Fire Chief
Joseph F. Beach, Director, Office of Management and Budget
Patrick Lacefield, Director, Office of Public Information
Scott Graham, Assistant Chief, Fire and Rescue Service
Anita Aryeetey, Sr. Management and Budget Specialist, OMB

Emergency Medical Transport Fee: Recommended Process, Rates, and Uses

Prepared for: Montgomery County Council Public Safety Committee

June 26, 2008

Background

- Montgomery County Fire and Rescue Service (MCFRS) provides emergency medical services (EMS) and transport through a comprehensive delivery system.
- This system is comprised of career and volunteer personnel, basic and advanced life support first response, as well as basic and advanced life support transports.
- MCFRS staffs 24 basic life support (BLS) ambulances 24/7 and 3 BLS "Flex Units" 12 hours per day, 18 medic units, 18 Advance Life Support (ALS) engine companies, 15 engine companies, 15 truck companies, and 6 heavy rescue squads operating from strategically selected locations.
- MCFRS provides a response to all emergency calls for ambulance transportation within the County. Emergency response is also provided for surrounding jurisdictions under mutual aid agreements. MCFRS responds to approximately 70,000 EMS calls which result in approximately 58,000 transports per year.

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Why the Fee is Needed

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands additional resources will be needed in the future for the following:

- Implementing four-person staffing.
- Opening new stations in the Upcounty area including Travilah, West Germantown, East Germantown, and Clarksburg.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting System (e-PCR). The Maryland Institute for Emergency Medical Services Systems previously announced it will discontinue paper reporting on December 31, 2008.
- Expanding the number of Officers consistent with supervisory and work hour requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.

Potential Use of Resources

The proposed EMST Fee will provide a substantial portion of the resources needed for these enhancements including those improvements identified below:

	FY09	FY10	FY11	FY12	Total
Operating Budget Impact - Staffing New Stations	$ 3,017,430	$ 6,327,000	$ 6,585,000	$ 9,284,000	$ 25,213,430
Apparatus Management Plan***		$ 7,000,000	$ 7,840,000	$ 8,780,800	$ 23,620,800
4 Person Staffing Phases 3-7		$ 4,101,000	$ 8,494,094	$ 13,200,086	$ 25,795,179
LFRD Allocation**	$ -	$ 1,500,000	$ 1,575,000	$ 1,653,750	$ 4,728,750
Electronic Patient Care Reporting System (EPCR)	$ 2,500,000	$ 100,000	$ 100,000	$ 100,000	$ 2,800,000
Total (Potential Use of Resources)	**$ 5,517,430**	**$ 19,028,000**	**$ 24,594,094**	**$ 33,018,636**	**$ 82,158,159**
*** Assumes 12% Cost Escalator in FY10-12					
** Illustrative Only (details pending further discussion with LFRDs and MCVFRA). Assumes a 5% increase per year.					

(58)

Projected Net Revenues

	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	**$ 7,047,790**	**$ 14,763,417**	**$ 15,471,092**	**$ 16,225,692**	**$ 53,507,991**
Costs					
Third Party Billing (5%)	$ 352,390	$ 1,476,341	$ 1,547,109	$ 1,622,569	**$ 4,998,409**
Community Outreach	$ 200,000	$ 50,000	$ 50,000	$ 25,000	**$ 325,000**
Initial Personnel Training	$ -	$ 25,000	$ 25,000	$ 25,000	**$ 75,000**
Manager Billing Services*	$ 105,500	$ 113,014	$ 121,064	$ 129,686	**$ 469,264**
Quality Compliance (2)*	$ -	$ 138,055	$ 147,888	$ 158,422	**$ 444,365**
IT Specialist - Hardware*	$ 85,250	$ 91,325	$ 97,830	$ 104,798	**$ 379,203**
IT Specialist - Data Analyst*	$ -	$ 91,325	$ 97,830	$ 104,798	**$ 293,953**
Office Service Coordinator*	$ -	$ 65,935	$ 70,631	$ 75,662	**$ 212,228**
Available Revenue	**$ 6,304,650**	**$ 12,712,421**	**$ 13,313,740**	**$ 13,979,757**	**$ 46,310,569**
* Assumes a 7% increase per year					

Administration of the Fee

1. No person regardless of ability to pay will ever be refused EMS treatment or transport by MCFRS.
2. Each EMS transport will result in a bill for service being sent to the patient's insurance company or the patient depending on two factors: Is the patient a County resident? Is the patient insured?
3. Patients who reside within the County will not receive a bill for services whether they are insured or not. An uninsured patient will receive a request for information regarding insurance coverage.
4. Patients who do not reside within the county will receive a bill for any applicable co-pay or deductible. A Request for Waiver will be included with the bill.
5. Patients who do not reside within the county and are not insured will receive a bill for the services. A Request for Waiver will be included with the bill.
6. Requests for Waivers will be granted by the Fire Chief based on whether the patient's household income is within the federal poverty guidelines.
7. Billing and collection functions will be contracted to a third party that specializes in EMS billing. This will ensure prompt, accurate, and cost effective collection services especially with the rapidly changing requirements of the various insurance services.
8. MCFRS will work with the local hospitals to provide insurance information to the billing contractor.
9. This information will be transmitted electronically to the contracted billing vendor to facilitate collections.
10. The billing vendor will be paid a negotiated fee for services. The Executive's revenue projections assume that the vendor will receive 5% of collected revenues.

(8)

Impact on Volunteer Corporations

- Ongoing discussion and coordination with the MCVFRA and Local Fire and Rescue Departments (LFRDs)
- Despite repeated inquiries with several jurisdictions, we have found no evidence to support the claim that emergency calls for service or patient transports decline after the imposition of an EMST Fee.
- Also no evidence that EMST Fees impair the development capacity of volunteer fire corporations.
- We will continue to discuss with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents.

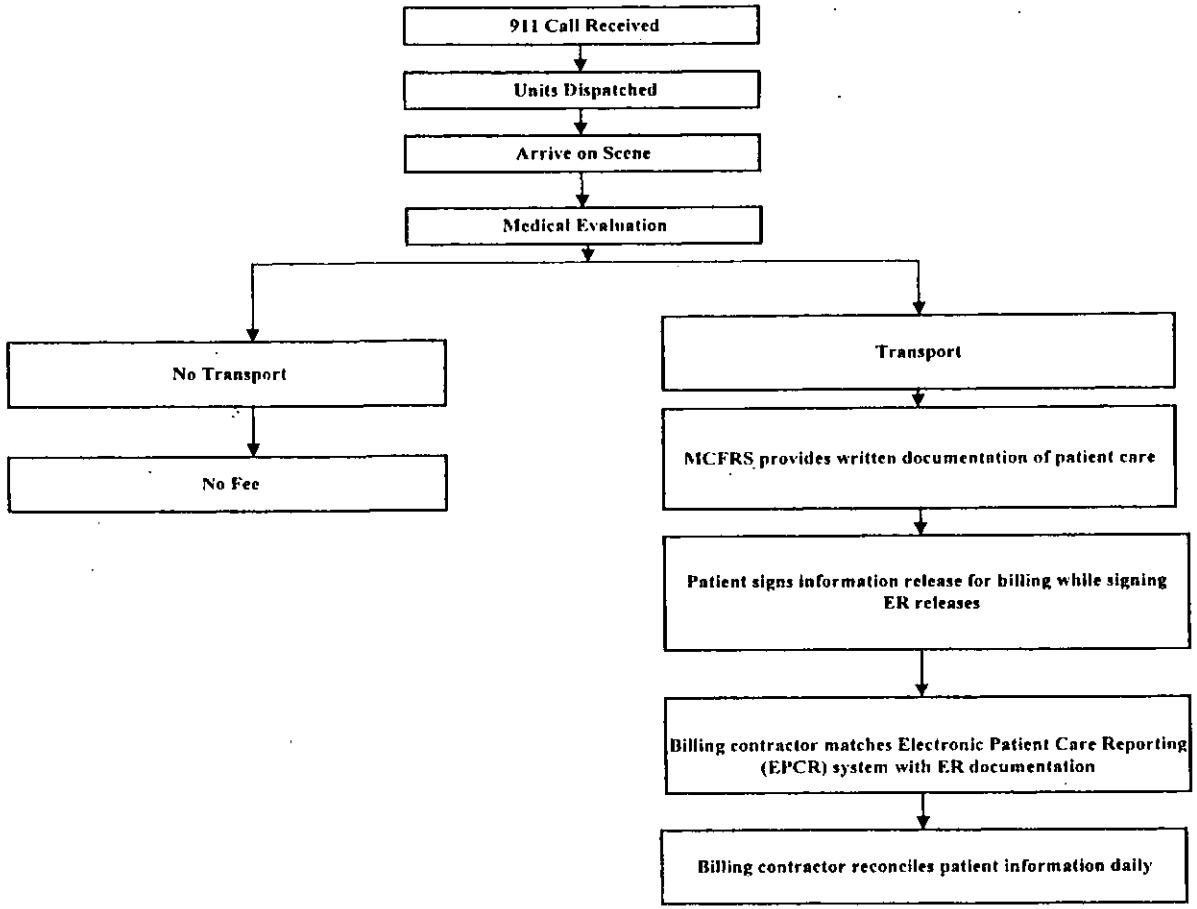
Community Outreach

The Executive recommends that $200,000 be appropriated for a community outreach campaign in the first year of implementation. The campaign would include:

- An informational mailer/card sent to all County households.
- Distribution of information through existing County and community email lists, blogs, and list serves.
- Radio and television public service announcements made available to the electronic media servicing the County.
- News releases and news events featuring information about the program.
- Information translated into Spanish, French, Chinese, Korean, Vietnamese, and other languages, as needed.
- Extensive use of County Cable Montgomery television and all the Public, Educational, and Government channels funded by the County.
- A speakers' bureau available to address community groups.
- Posters and brochures made available at all County events and on Ride One buses and through: Regional Service Centers; Public Libraries; Recreation facilities; senior centers; ESL classes; MCPS; Montgomery College; health care providers; hospitals and clinics; and other venues.
- Informational brochures will be made available to hospitals to provide to patients transported.
- Special outreach to the senior community and to the County's "New American" communities.

(62)

Emergency Medical Service Transport Fee Business Process



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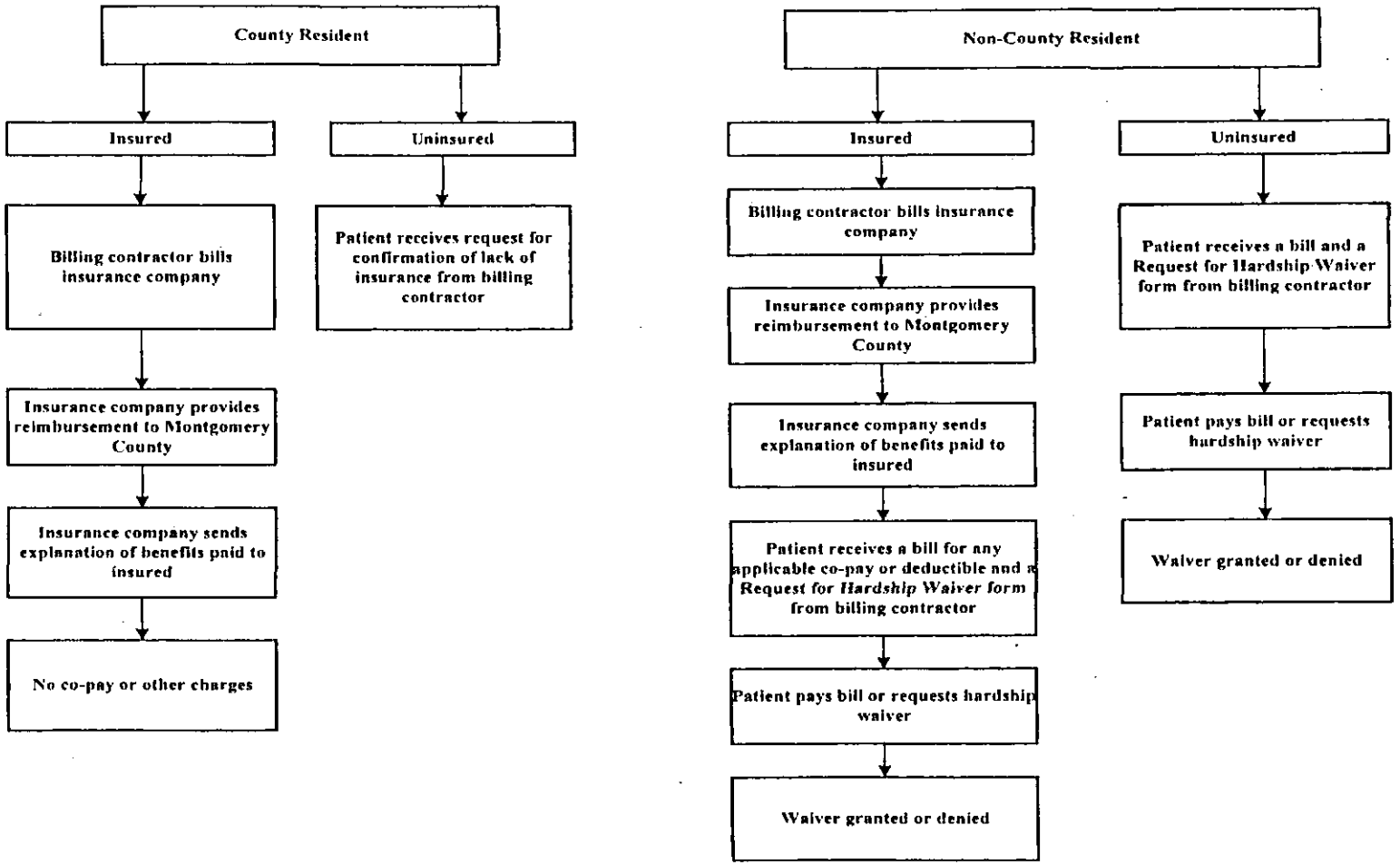
Emergency Medical Service Transport Fee: Resident vs. Non-Resident



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Other Jurisdictions

- Many jurisdictions throughout the nation and regionally have successfully implemented EMST Fees
- We have not found any evidence that EMST Fees have led to a reduction in the number of 911 calls or transports or impaired the development capacity of volunteer corporations.
- The fee programs have consistently produced substantial resources to fund fire and rescue services

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EMST Fees In Other Jurisdictions

	Emergency Medical Services Transport Fee: Regional Comparison				
	Fairfax County	**Arlington County**	**Alexandria City**	**Fairfax City**	**District of Columbia**
Annual Transports	45,000	9,500	7,500	3,860	82,410
Rates:					
Basic Life Support (BLS)	$400	$400	$400	$400	$268
Advanced Life Support 1 (ALS 1)	$500	$500	$500	$500	$471
Advanced Life Support 2 (ALS 2)	$675	$675	$675	$675	$471
Flat Rate for all services					
Transport Per Mileage Charge	$10.00	$10.00	$10.00	$8.50	$0.00
Agency Type	Combined Volunteer and Career	Career	Career	Career	Career
Year Program Established	2005	1998	1968	2008	1983
Amount Collected	$10,955,015	$2,997,788	$1,483,390	Program began January 2008	$14,168,292
	Prince Georges County	**Baltimore City**	**Anne Arundel County**	**Frederick County**	
Annual Transports	35,000	82,577	45,000	14,837	
Rates: *					
Basic Life Support (BLS)	$400	$350	n/a	$360	
Advanced Life Support 1 (ALS 1)	$500	$410	n/a	$450	
Advanced Life Support 2 (ALS 2)	$750	$410	n/a	$525	
Flat Rate for all services			$500		
Transport Per Mileage Charge	$5.00	n/a	n/a	$8.00	
Agency Type	Combined Volunteer and Career	Career	Combined Volunteer and Career	Combined Volunteer and Career	
Year Program Established	1986	1989	2008	2003	
Amount Collected **	$1,500,000	$11,399,085	Program authorized in May 2008	$3,353,143	

* Most recent rates adopted by the jurisdiction

** Amount collected is for Calendar Year 2007

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The Choices

1. Defer the necessary improvements until there are sufficient resources.
2. Increase the property tax:
   a. +1 cent = $16.1 million in FY09;
   b. +1 cent = $16.7 million in FY10
3. Reduce funding to other services and redirect to MCFRS priorities.
4. Implement an EMS Transport Fee that is funded through insurance reimbursements rather than from County taxpayers.

(67)

continued from previous panel

The quality of patient care will continue to be the highest priority for *Montgomery* County's Fire & Rescue Service. A resident's ability or non-ability to pay will never be considered when providing service.

When a resident makes that 911 call, the first priority will be to take care of that patient's immediate medical needs. If deemed necessary, the patient will be transported to the hospital. If not, the EMS fee will not be charged to the insurance company.

If you have questions or concerns about the proposed EMS fee, **contact Scott Graham in the Montgomery County Fire & Rescue Service at 240-777-2493 or scott.graham@montgomerycountymd.gov.** For information about fire and life safety education programs or non-emergency fire and rescue issues, call 240-777-2400.

EMERGENCY HELP
Dial 911

Montgomery County
Office of Public Information
www.montgomerycountymd.gov

Emergency Medical Services Transport Fee

Maintains and Strengthens Services at No Cost to Residents

Here are the facts:

- **An EMS transport fee will raise $14-$17 million a year in revenue** that will be dedicated to maintaining and enhancing Montgomery County's world-class emergency medical services.

- **County residents will not pay anything under the new fee, and they will never see a bill,** pay a co-pay or file a form for emergency medical transport. The fee will be billed directly to residents' insurance companies, which have already factored the cost of patient transport into their rate schedules. The fee will be waived for uninsured residents.

- **Montgomery County is one of the few jurisdictions in the region that is not already (or in the process of) collecting an EMS fee** from insurance companies. Fairfax County collects the fee, as well as Frederick, Prince George's, Carroll, Charles, Arlington, and Washington counties. Cities such as Alexandria, Baltimore, and the District of Columbia also collect the fee.

- **There is no evidence that those in need of transport will be dissuaded from calling 911** because their insurance is going to be billed or because they are uninsured. In the jurisdictions that have been collecting this fee, there is no evidence of that happening. Montgomery County will fund a public education campaign to make sure that residents know there are no charges to them for emergency medical services and no changes in service.

- **Insurance rates will not rise because of this fee,** since it is already factored into the insurance company rate calculations. Individual insurance coverage will be considered payment in full, and the fee will be waived for uninsured residents.

- **Montgomery County will have agreements with area hospitals to provide insurance information** for patients who are transported. A third party billing company will be contracted by the County to collect the fee from the insurance companies, including Medicare. Any costs associated with collecting the EMS fee will be greatly offset by the new revenue.

continues on next panel

Frequently Asked Questions

Emergency Medical Services Transport Fee

1. What is the Emergency Medical Services Transport (EMST) Fee?

The EMST Fee will be charged electronically to heath insurance companies of County and non-County residents who are transported to County hospitals by the Montgomery County Fire & Rescue Service (MCFRS). The net proceeds of the EMST Fee will go entirely to strengthening and improving fire and emergency services in Montgomery County. The imposition of the fee will not affect access to the excellent services now provided by MCFRS – except insofar as it strengthens those services by directing more resources to those needs.

2. Will I see any difference in Montgomery County EMS service?

No. MCFRS will continue to provide the very best service to any individual in need regardless of ability to pay – just the way it's always worked.

3. Who pays the fee?

The health insurance companies of County residents and non-County residents. County residents with health insurance will not be responsible for co-pays or deductibles. County residents without health insurance will not be charged. Non-County residents with health insurance may be responsible for co-pays and deductibles depending on their policies. Non-County residents without health insurance will receive a bill, along with a request to waive the fees under hardship guidelines

4. Why is the fee necessary?

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands, improve response time, and enhance firefighter/rescuer officer safety, several enhancements have been initiated within MCFRS and will require additional resources in the future including:

- Implementing four-person staffing.
- Opening four new stations in the Upcounty area.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting (e-PCR) System. On December 31, 2008, the Maryland Institute for Emergency Medical Services Systems will discontinue paper reporting. Currently MCFRS utilizes this method. MCFRS must quickly implement on a fast track, an e-PCR program in order to meet State of Maryland requirements as well as be fully capable of complete revenue recovery.
- Expanding the number of officers consistent with supervisory and work hour

requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.
- Maintaining high levels of service to all parts of the County.

Also a factor is the pressure on County government budgets caused by economic uncertainty, declining housing markets, the state of Maryland's budget crisis, and other factors. This has caused program reductions and increased property taxes. Clearly, a new revenue source dedicated to MCFRS would help ensure that fire and rescue services are adequately funded in the future.

5. Where will the money raised by the EMST Fee go?

100 percent of the net proceeds of the EMST Fee will go to strengthen and enhance the MCFRS. By law, they will be dedicated to that purpose and cannot be used for anything else.

6. Will there be co-pays and deductibles?

No, not for County residents. Non-County residents mayl be responsible for co-pays and deductibles, depending on their policies.

7. Do other area governments have an EMST Fee?

Nearly all of our neighboring jurisdictions either have an EMST Fee or are moving to implement one. These jurisdictions include Fairfax County, Frederick County, Prince George's County, the District of Columbia, Arlington County, and the city of Alexandria.

8. How about local governments in other parts of the United States?

The 200 City Survey in the 2006 Journal of Emergency Medical Services (JEMS) reported that, across the U.S., an average of 61% of EMS system funding comes from user fees.

9. Will this fee deter people from calling 911 for ambulance service?

There is no evidence from jurisdictions that have successfully implemented this fee that it deters anyone from calling for needed emergency medical transport assistance.

10. Will this fee cause health insurance rates to increase?

There is no documented evidence that ambulance bills affect underwriting of risks for insurance premiums. Ambulance bills are in the "hundreds" of dollars, compared to hospital, physician, surgeon, rehab, device, and drug bills, which are typically in the "thousands and tens of thousands." Ambulance expenditures account for less than 1% of insurance expenditures. Since most insurance companies determine rates on a regional basis – and most jurisdictions in the region bill insurance companies for this

charge – in most cases County residents may already be paying for ambulance service as a part of their premiums.

11. What charges will be billed to insurance companies?

Insurance carriers would be billed at the following rates, depending on the level of services necessary:

• Basic Life Support – Non-emergency*	$300.00
• Basic Life Support – Emergency*	$400.00
• Advanced Life Support – Level 1 – Non-Emergency*	$350.00
• Advanced Life Support – Level 1 – Emergency*	$500.00
• Advance Life Support – Level 2*	$700.00
• Specialty Care Transport*	$800.00

* The terms in the schedule are as defined in 42 CFR Parts 410 and 414.

In addition, insurance companies would be billed $7.50 per mile on emergency transports, a standard charge for most implementing jurisdictions.

If the EMS call does not result in transport to a hospital, the health insurance carrier or the non-County resident without insurance would not be billed for anything.

According to the 2006 JEMS "200 City Survey," here are *average* charges in the 200 largest cities in the U.S.

Average Charges for Transport Providers

	Average	Governmental	Non-Governmental
BLS Non-Emergency	$396.26	$375.91	$411.52
BLS Emergency	$473.02	$457.92	$492.94
ALS Non-Emergency	$548.04	$514.50	$574.87
ALS 1 Emergency	$625.68	$573.09	$700.52
ALS 2 Emergency	$711.42	$639.58	$802.85

12. What if my health insurance plan only pays a certain amount for ambulance services or refuses to pay? Will I have to pay the balance?

The County will accept whatever payment the insurance company has established as "payment in full." County residents will not be responsiblie for any co-pays or deductibles. Non-County residents will be responsible for any applicable co-pays or deductibles.

The single biggest payor for these services is Medicare. If coverage requirements are met Medicare has no discretion to deny claims. Heath insurance companies are required by law to pay covered services, of which ambulance services is one. Any question about any Medicare or insurance company payment would be handled by the third-party vendor and would not involve the covered individual.

13. How will this fee affect Local Fire & Rescue Departments ("Volunteer Companies")?

Local Fire & Rescue Departments would deliver services just as they do now, the only difference being the entry of a code into the electronic tracking system to enable the contracted billing agent to process insurance company payments or, in the case of non-County residents without insurance, to bill for the service, with accompanying information about hardship waivers.

The County has discussed with Local Fire & Rescue Departments potential opportunities to offset any unexpected reductions in their local fundraising that might conceivably result from the implementation of an EMST fee – although there is no evidence in other jurisdictions of a drop-off in donations owing to the implementation of an EMST Fee.

14. How will the billing to insurance companies work?

Data will be entered by EMS personnel in the Electronic Patient Reporting System, which will be required by the State – independent of any EMST Fee – starting December 31, 2008. Paper reporting, currently used by MCFRS, will no longer be accepted. That information will be examined by the third-party vendor responsible for billing health insurance companies and non-County resident without insurance.

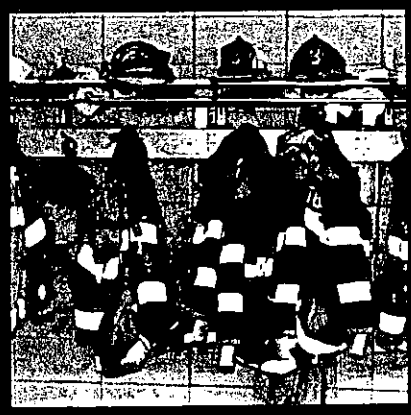
15. What will be the start-up costs for this program? What will be the ongoing expenses?

The County is projecting about $700,000 in start-up costs for the first half year, half of which is the 5 percent of proceeds payment to the third-party billing vendor. Once the program is up and running, the overhead costs are estimated at 13-14 percent of total revenue – again, including the five percent going to the third-party billing vendor.

16. Will there be efforts to educate County residents about how the system works – and how no County residents will pay out-of-pocket?

While there is no evidence from any of these jurisdictions that adoption of an EMST fee has resulted in any diminution of calls for 911 emergency transport or any reluctance of residents to call for needed services due to a misunderstanding that they might incur a fee, a solid campaign of public outreach and education just makes good sense. Such a campaign would begin several months before the program actually began and extend several months afterward.

Revised June 21, 2008



You're invited to attend a discussion about the proposed

Emergency Medical Services Fee

Montgomery County Fire & Rescue Chief Thomas W. Carr Jr. will host four "town hall" meetings to talk about the proposed emergency medical services transport fee and senior fire safety.

Wednesday, June 11 at 1 p.m.
Damascus Senior Center
Routes 109 & 27

Tuesday, June 24 at 10 a.m.
Holiday Park Senior Center
3950 Ferrara Drive, Wheaton

Thursday, June 26 at 1 p.m.
Margaret Schweinhaut Senior Center
1000 Forest Glen Road, Silver Spring

Friday, June 27 at noon
Long Branch Senior Center
8700 Piney Branch Road, Silver Spring

The meeting is free and open to the public.
For more information, call the Office of Public Information at 240-777-6530.

Testimony of John T. Bentivoglio

on behalf of the

Bethesda-Chevy Chase Rescue Squad, Inc.

before the

Montgomery County Council's Public Safety Committee

July 8, 2008

I appreciate the opportunity to provide this testimony on behalf of the Bethesda-Chevy Chase Rescue Squad, Inc. I am a Bethesda resident and have had the pleasure of serving as a firefighter and EMT with BCCRS for 19 years. I also serve as outside legal counsel to BCCRS.

The Bethesda-Chevy Chase Rescue Squad strongly opposes the imposition of ambulance fees in any form. Our opposition is based on both policy and practical grounds.

Ambulance fee supporters have cited -- often with little or no supporting evidence or analysis -- that such fees can generate substantial revenues with little or no impact on County residents. They also have cited the budget needs of the County's fire/rescue service in justifying ambulance fees.

We have examined these issues closely. We believe a close review of the facts will show that the Executive's proposal is deeply flawed. Our review has found:

- Ambulance fees may deter people from calling 911 for ambulance service;
- Many County residents will be charged for ambulance service;
- The revenue estimates are vastly overstated;
- The Fire/Rescue System does not need additional revenues; and
- A significant portion of the revenues will not be used exclusively to bolster the fire/rescue system but will be diverted to other uses.

1. A fee will deter people from calling 911

Ambulance fee supporters have cited no study or analysis showing that ambulance fees don't deter people from calling 911 in a medical emergency.

The fact that call volume hasn't decreased in jurisdictions imposing ambulance fees (such as Fairfax County) is more likely explained by population growth in these jurisdictions. These jurisdictions have not conducted surveys of impacted populations (such as the poor or uninsured) to determine whether ambulance fees of $500 to $800 will deter calls to 911.

We have found several studies suggesting that patient fees/costs will deter people from calling 911. For example:

> "Economic considerations may affect EMS system utilization among underinsured and low-income patients experiencing a cardiac event," cited in *Association between prepayment systems and emergency medical services use among patients with acute chest discomfort syndrome (for the Rapid Early Action for Coronary Treatment (REACT) Study)*, Ann Emerg Med. 2000 Jun;35(6):573-8.

> "The results of this study indicate that indecision, self-treatment, physician contact, and **financial concerns** may undermine a chest pain patient's intention to use EMS," cited in *Demographic, Belief, and Situational Factors Influencing the Decision to Utilize EMS Among Chest Pain Patients*, Circulation (Journal of the American Heart Association), 2000:102; 173-178.

The problem with relying on reports from other jurisdictions with ambulance fees is they have a vested interest in painting a rosy and positive picture of ambulance fees -- and minimizing negative impacts.

2. The burden will fall most heavily on the poor, elderly, non-English speakers, and other vulnerable populations

The burden of ambulance fees will fall most heavily on the poor, elderly, non-English speakers and other vulnerable groups. Most people who are uninsured or underinsured are poor and working poor -- those too "rich" to qualify for Medicaid but too poor to afford health insurance.

With respect to the elderly, non-English speakers, and others, if they don't have insurance they are likely to receive bills from the County for ambulance services. Under the Fairfax County system (often cited by ambulance fee supporters), residents receiving bills must submit extensive paperwork (including tax filings or other financial documents) to request an ambulance fee waiver. This won't feel like "soft billing" (as ambulance fee supporters promise) won't seem "soft" to many residents, who will assume that if the County is demanding payment, the resident must pay.

3. The Fire/Rescue Service Has Not Demonstrated A Compelling Need for Additional Resources

The County Executive's FY09 Budget Proposal shows the following for FY09:

Fire/Rescue Expenditures	$190,716,110
Fire/Rescue Revenues (with ambulance fees)	$209,320,490
Revenues (without ambulance fees)	$202,273,000

In fact, Fire Tax receipts alone in FY09 are projected at $193,905,290. In other words, the Fire Tax pays for more than 100% of the Fire/Rescue Operating Budget. The excess funds, plus other revenues (grants, etc), should provide more than $12 million in funding for capital expenditures in FY09 -- without the Ambulance Fee.

4. Hundreds -- potentially thousands -- of County residents will be charged for emergency ambulance service

Ambulance fee supporters have promised to pursue an "insurance only" billing policy, under which County residents would be billed only to the extent of available insurance. (Memo from Joseph Beach (Director, OMB) to Michael Knapp, April 14, 2008 at page 5 of report submitted by Page, Wolfberg & Wirth ("PWW Report"). However, the projections offered by the County Executive include the following:

	Year 1	Year 4
Self-Pay Transports	15,954	17,945
Self-Pay Charges	$ 7,920,960	$10,219,540
Self-Pay Revenues	$792,096 (10% of self-pay charges)	$1,021,954 (10% of self-pay charges)

5. The County's revenue projections for the ambulance fee are dramatically overstated

The report by the County's outside consultant/law firm states that the revenue projections "[a]ssume[] complete documentation necessary to support billing decisions; crew documentation training recommended." (See PWW Report, "Notes and Assumptions" for each year's revenue projections). The report also states:

> "Detailed documentation training will be required of all EMS personnel in the County to fully realize these revenue projections. Montgomery County policymakers and budget officials might want to take this factor into account when considering their anticipated EMS revenue budgets and reduce the projections by some estimated favor (for instance, 40% in Year One, 30% in Year Two, 20% in Year Three, and 10% in Year Four) to account for this unpredictable variable." (PWW Report, page 7 under "Patient Care Documentation").

Despite these explicit caveats, the April 14, 2008 Memorandum from Joseph Beach (OMB Director) to Michael Knapp states that "the legislation is expected to result in revenues of $7.05 million in FY09, assuming mid-year implementation, and annual revenues of $14.8 million in FY10 ...."

The truth is that while County budget officials promise $14.8 million in 1st year revenue, under the County's own estimate the actual amount is likely to be closer to $8 million/year -- and even that amount overstates the likely near-term revenues.

The April 14, 2008, Memorandum cites personnel costs of $466,500 annually and operating costs of $352,390. However, the Memorandum provides no estimates for the acquisition of an Electronic Patient Care Reporting System.

Perhaps more importantly, there is no estimate for the cost the third-party billing company will charge the County. In other jurisdictions, such charges are in the range of 9% of revenues collected -- which could exceed $1 million in the first year of the program alone.

Finally, despite the recommendation of the outside consultant/law firm to provide EMS provider training on patient care documentation to support billing, there is no money allocated in the budget for such training.

As a result, we believe that the likely first-year revenues are more likely to be $5-6 million; with revenues increasing no more than $1 million/year through the first four or five years of the ambulance fee.

6. The ambulance fee will not necessarily be devoted to strengthening the fire/rescue service

The legislation forward by the County Executive states that the revenues derived from the ambulance fee would not be used to supplant other revenues. Yet this language is much "softer" than language included in the 2004 ambulance fee proposal. That earlier language directed that the ambulance fee revenue be used solely for specified fire/rescue services. Why didn't the Executive's draft legislation include this much stronger language?

* * * * *

It is important to note that we have come to these conclusions based on our own analyses and fact gathering. We have seen little or no analyses or studies supporting many of the Executive's arguments in favor of ambulance fees.

In conclusion, we appreciate the opportunity to submit this testimony and look forward to working closely with the Council on the ambulance fee issue.

Thank you.

11

4 Falls Chapel Court
Potomac, MD 20854
July 8, 2008

Michael J. Knapp
Council President
Montgomery County Council
Stella B. Werner Office Building
Rockville, MD 20850

In re: Emergency Medical Transport Fee

Dear Council President Knapp:

Previously during the budget process hearings I had spoken against the imposition of the ambulance fee covering three points. First, it is my belief that the evacuation of sick and injured residents to emergency medical facilities is an essential government function that should be paid for under existing tax regimes. Second, existing tax gathering programs are very efficient for example the Comptrollers' office can collect a dollar's worth of State/County income tax for less than 1/3 of a cent. Third, increasing the costs of the usual payers of medical services such as insurance companies will ultimately lead to increased premium costs to County residents. (Part of such cost increases when premiums increase is the premium taxes that Maryland companies (to include health maintenance organizations) pay.)

The essence of insurance is risk shifting and risk distribution. When a baby comes into a family by law and custom the provision of paying for the child's medical services is shifted to his or her parents. Risk distribution is a math concept. Entities that assume risks are typically an insurance company or a large employer in a self-insured medical plan. Such entities take advantage of the statistical phenomenon known as the law of large numbers. Thus, there is an increase in predictability of the average loss that will be incurred by the company on each risk that it has undertaken. This increase in predictability helps protect the company's solvency. The short of it is that on an actuarial basis with nearly a million people in the County risk distribution can be achieved and we should not have a year where we would have a spike with say 200,000 ambulance transports. I do not see any need to go outside the non-fee ambulance system that we have paid by our taxes, which, by the way, for the most part are deductible on our tax returns for those that itemized. Likewise some of the volunteer corporations have sufficient numbers of calls to achieve risk distribution, which corporations are funded in large part by contributions which are also deductible on our tax returns.

When one charges a fee some costs occur which should be considered by the County Council. Running the collection program can run say from 7 to 20% to collect a dollar (20% was the cost estimated in the proposal 5 years ago). Also training may be necessary that has nothing to do with the mission of the Fire and Rescue Service but is done by the collection agent staff solely to get claims through the claims people at the insurance companies on the medical necessity of the transport issue. Right now we seem to be free of any such window dressing kind of thing.

I should also point out that insurance is not just a little complicated. For example, most policies in the Federal Employees Health Benefit Program state some sort of coverage

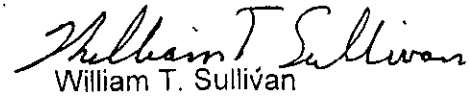
for ambulance fees, however, they also have some general exclusions clauses which, in essence, take those stated the benefits away. For example, my plan does not cover: "[s]ervices or supplies for which no charge would be made if the covered individual had no health insurance coverage." Based on this general exclusion clause my plan has written me a letter dated June 11, 2008, stating that it would deny payment of the fee to the County. Maryland only mandates ambulance service coverage for certain small employer plans containing 50 or fewer persons and all of the other health plans that it regulates the parties are free to negotiate ambulance service coverage in or out. However, it is interesting to note that the small employer plan has a general exclusion provision barring payment for "[s]ervices for which a covered person is not legally or as a customary practice required to pay in the absence of a health benefit plan."

I see the Montgomery County proposal as being different from the Fairfax plan which the proponents have claimed to have copied. That is, in Fairfax, the county resident appears to be billed according to their waiver form and is asked not only to assert that they have no insurance but also to provided income information. In my submission to the Council I have it in writing that a Fairfax county resident without insurance with sufficient income will be required to pay their ambulance fee.

All of these ambulance fee proposals of the various counties that waive the co-pays and deductibles, in my personal view, create problems that can put paperwork burdens on residents that have flexible spending accounts tied into their health plans. For example, assume a doctor charges a patient $100 for his services and insurance pays $80 and the patient responsibility is $20. The connected health plan and Flex would result in $20 being transferred from the Flex account to the patient's personal bank account. This is what should happen because the patient owes the doctor the $20. If an ambulance fee is $400 and the insurer pays $300, the explanation of benefits will say the patient responsibility is $100. However, in the case of a waived $100 fee the $100 really has no business going out of the Flex account into the patient's personal bank account.

Some may perceive that the fee proposal operates unfairly and may this well generate confusion as to how the program actually works. I understand the current proposal not only co-pays are waived but deductibles are waived as well. Two different people could be transported at the some time but only the person whose explanation of benefits was processed before any other explanation of benefits first might get the benefit of the County's waiver program as to that deductible. In other words, I am assuming that the second party was unluckily enough to have his hospital bill processed first and when the County's medical transport bill was processed by the insurer the annual deductible had already be absorbed so there was no annual deductible available at that time for the County to waive (just the co-pays).

Sincerely,



William T. Sullivan
301-340-9513

GEHA®

The Health Plan *for* Federal Employees

June 11, 2008

ES20080609373

WILLIAM T SULLIVAN
4 FALLS CHAPEL CT
POTOMAC MD 20854-2433

MEMBER NAME: WILLIAM T SULLIVAN
ID: 22893963
Patient: William T Sullivan
Re: Ambulance Charges

Dear Mr. Sullivan:

This is in response to the information you provided concerning the proposal of the Emergency Medical Services Transport Fee (EMST Fee) for ambulance services provided in Montgomery County, MD.

Thank you for bringing this information to our attention. We have discussed this matter with the insurance contract area of the Office of Personnel Management (OPM) and representatives of other FEHB Plans. If this proposal is enacted, GEHA would deny the EMST Fee from Montgomery County Fire and Rescue for Montgomery County residents. This is based on a specific exclusion on page 65 of the brochure that states we will not cover services or supplies for which no charge would be made if the covered individual had no health insurance coverage.

We have referred this issue to the Office of General Council of OPM.

Please continue to update us on the status of this proposal in Montgomery County.

If you have any questions, please contact me.

Sincerely,

Jane Overton
Vice President-Claims
Claims Department

JO:pl

FAIRFAX COUNTY FIRE AND RESCUE DEPARTMENT

Request for Ambulance Fee Waiver

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT INCIDENT BILLED

APPLICANT NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____(W)_____(H)_____(C)

****MONTHLY* HOUSEHOLD *GROSS* INCOME FOR ALL ADULTS WHO WORK AND SHARE INCOME AND EXPENSES IN YOUR HOUSEHOLD: $_____**

HOUSEHOLD SIZE (number of people):_____

***You must provide documentation to substantiate your monthly household gross income. Attach two current pay stubs or last year's tax return. Other acceptable documents: financial aid approval from Inova or other hospital; social security statement; unemployment commission letter; homeless shelter letter.*

If you claim no income, attach a letter of explanation.

I am applying to Fairfax County Fire and Rescue Department to request a waiver of payment for my ambulance transport fee. I certify that I have no insurance that can be billed for this charge, that the above information is true and accurate to the best of my knowledge, and that I will be held responsible for any false statements made herein.

_____ _____ _____

Signature **Printed Name** **Date**

If you have any questions please call 703-246-2266. Please mail completed form and applicable documents to:

FAIRFAX COUNTY VIRGINIA
P.O. BOX 630232
BALTIMORE, MD 21263-0232

Sullivan William T

From: Mangione, Katie [Katie.Mangione@fairfaxcounty.gov]
Sent: Tuesday, May 06, 2008 1:36 PM
To: Sullivan William T
Subject: RE: Montgomery County Ambulance Fee

I am not sure what you are saying. We have hardships based on income. You could not have $2M in income that you tell us about and get a waiver.

We look at the individual circumstances but would not automatically waive out of county residents.

From: Sullivan William T [mailto:William.T.Sullivan@IRSCOUNSEL.TREAS.GOV]
Sent: Tuesday, May 06, 2008 1:07 PM
To: Mangione, Katie
Subject: Montgomery County Ambulance Fee

<<Ambulance_fee.pdf>>

Hi Katie,

It appears that the Montgomery County fee plan is different for yours. For example, your waiver form asks for household income information. Would a Fairfax County resident without insurance but with $2 million of annual income and $50 million in net assets - get a free ride??

Any ideas? (It looks like your waiver form applies to Fairfax County residents and it is not just a form for out of county residents.)

The proposed legislation in Montgomery County 21-23A(c)(1) states that "[a] resident of Montgomery County is responsible for the payment of the emergency medical service transport fee only to the extent of the individual's available insurance coverage." As I understand it from Chief Graham information will be requested with one question only - do you have insurance? If not - the fee will not be collected. If one doesn't answer the inquiry from the county the first time on the "do you have insurance question" - 2 more inquiries will go out and no more inquiries will be made after that.

Thanks,

Bill Sullivan
(202) -622-7052

William.T.Sullivan@IRSCOUNSEL.TREAS.GOV

Testimony
Montgomery County Council Public Hearing
Ambulance Billing
7/8/2008
Chief Allan Platky
Wheaton Volunteer Rescue Squad, Inc.

Good evening President Knapp, Council Members, ladies and gentlemen. My name is Allan Platky and I am the Chief of the Wheaton Volunteer Rescue Squad Inc. I rise to speak against the implementation of ambulance billing.

As a member of the Montgomery County Volunteer Fire Rescue Association we support the position taken by that organization on this issue. In the interest of brevity I will not restate the MCVFRA's position but rather provide additional perspective from the position of our Department.

The Wheaton Volunteer Rescue Squad is one of the local volunteer fire rescue departments that make up the Montgomery County Fire & Rescue Service. The department was founded in 1955. We own and operate 3 basic life support ambulances, 3 advanced life support medic units, 2 heavy rescue squads, 1 special service EMS vehicle and 4 support vehicles. We have approximately 130 active volunteers who are committed to staff the station nights, weekends and holidays. Our ambulances and medic units respond to approximately 7% of all of the EMS calls in the County. Approximately 64% of the staffing for the station is provided by our volunteers. The bulk of our operational funding is from donations.

With that brief background I would like to speak specifically to our concerns:

1. **Billing will impact our ability to recruit and retain volunteers.** Billing is fundamentally divergent to the principles of volunteerism. Our organization was founded as a mechanism for neighbors to help neighbors during a time of need. Our members volunteer to give to the community. Montgomery County sending a bill for the services rendered by our members is demoralizing and cracks the foundation of the LFRD's.

2. **Billing violates our corporate articles of incorporation.** Consistent with the founding philosophy of our organization, our articles of incorporation state in part that the purpose of the organization is:

   *To provide, offer and make available, **without charge,** emergency rescue service to the residents of Wheaton and the surrounding areas.*

   When this concern has been raised with County staff we have been told that since the County is billing it would not be a violation of our articles of incorporation. The legal meaning of the words may be debated in the future by others, but the current proposal certainly violates the spirit and intent of the articles drafted by our founders.

3. **We are concerned about the impact on our fundraising.** We support the bulk of our operations from private donations. We purchase all of our own apparatus. We feel that it is important to the community we serve to control the assets associated with that service. A negative impact to fundraising could cause us to lose control of the assets necessary to provide our service.

   The executive branch has conceded that there may be some reduction in fundraising (although we had been told there was no evidence of this). There has been an offer to replace lost fundraising through additional appropriations. This does not address the issue of control of assets nor does it address the value of future fundraising activities.

   WVRS is diligently working with the County to develop a badly needed, jointly funded station for our operations. The unknown potential impact of this legislation on our fund raising for the station could compromise our ability to support the 50% funding split.

4. **The proposed approach takes money from down County residents and supports up County growth.** The plan proposes a "service fee" for EMS service when in fact the information presented shows EMS in the lower County supporting fire service growth in the upper County. This is not a service fee but rather a user tax. WVRS responds to approximately 7% of the County EMS calls; however the proposed return to the citizens of Wheaton from this fee does not approach a proportional or fair distribution.

5. **The information provided indicates that this fee would be paid by insurance and the County residents would not have to pay if insurance was not available.** This language is not in the law, but rather the Fire Chief is given discretion to waive the fee. If this is a fundamental premise then the exception for paying should be in the law. Several insurance companies including those serving federal government employees, such as the Government Employees Health Association, have indicated that the fee is not covered by insurance based on the proposed method of implementation. This discredits any funding projections from the legislation.

In closing I urge you to vote against ambulance billing. Thank you for your time.

B 25-08

MF

MD

Guthrie, Lynn

From: Knapp's Office, Councilmember
Sent: Tuesday, July 08, 2008 10:53 AM
To: Montgomery County Council
Subject: FW: Ambulance fees

036797

-----Original Message-----
From: Erin Gilland Roby [mailto:erin.gilland_roby@yahoo.com]
Sent: Tuesday, July 08, 2008 10:33 AM
To: Andrews' Office, Councilmember; Knapp's Office, Councilmember
Subject: Ambulance fees

I am sending this message to you because I noticed in the Washington Post article that both of you seemed to have serious reservations about this. And you should.

My name is Erin Gilland Roby. I am a former volunteer firefighter from Howard County, and a former paid 911 fire dispatcher for Howard County and an EMS dispatcher in Honolulu. I also have a law degree. I cannot attend the hearing tonight to testify, but I thought you should be aware that this proposed fee has significant legal ramifications for both paid and volunteer personnel. I have sent essentially the same message to both volunteer and paid personnel.

I have been really concerned to see that the paid personnel have not taken a position on ambulance fees given the huge stake they have in the matter. Did you know that under Maryland law, paid personnel are protected from lawsuits (except in cases of gross negligence) as long as the patient is not charged for the services? The minute Montgomery County institutes charges, that protection will be GONE. While the county may have to indemnify the employee, and even supply an attorney, being involved in a lawsuit can be emotionally draining, something emergency personnel just do not need. Additionally, there is no guarantee that even if the caregiver were not negligent, that that would be the outcome in court, particularly when the plaintiff was a sympathetic one.

The controlling case is Tatum v. Gigliotti, 321 Md. 623 (1991), a Prince Georges County case [they were already in the process of instituting ambulance fees when this decision came down] that was decided by the Maryland Court of Appeals.

Here is an opinion from the Office of the Attorney General on this very issue, which also makes clear that instituting fees will destroy the immunity of volunteers as well:
http://www.oag.state.md.us/Opinions/1995/80OAG341.pdf

If you have any questions, I can be reached on my cell at 443-472-0261. I will be at work until 5, but I can take short calls, and I will check my e-mail frequently.

Sincerely,
Erin Gilland Roby

Editor's note. — Section 9, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, transferred former §§ 5-302 and 5-303 of this article to be present §§ 5-601 and 5-602 of this article, respectively.

§ 5-602. Emergency defense and civil defense shelters.

(a) *Definitions.* — In this section, "emergency management and civil defense" and "emergency" have the meanings stated in the State Emergency Management and Civil Defense Act.

(b) *In general.* — No action for damages may be brought against a person, firm, or corporation who allows premises which he owns, controls, or occupies to be used, free of charge, for one of the following purposes:

(1) Sheltering persons during an attack or raid by an enemy; or

(2) Stocking of food, water, medical supplies, equipment, or other materials to be used in the event of an attack upon the United States; or

(3) Sheltering persons during an emergency.

(c) *Application of section.* — This section applies only to injuries to person or property incurred on or adjacent to the premises:

(1) During an actual or practice attack or raid;

(2) While supplies and materials are being moved or stored;

(3) During an emergency; or

(4) During inspections or visits connected with emergency management and civil defense. (An. Code 1957, art. 16A, § 37; 1973, 1st Sp. Sess., ch. 2, § 1; 1975, ch. 666, § 6; 1981, ch. 505, § 2; 1997, ch. 14, § 9.)

Editor's note. — Section 9, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, transferred former §§ 5-302 and 5-303 of this article to be present §§ 5-601 and 5-602 of this article, respectively.

§ 5-603. Emergency medical care.

(a) *In general.* — A person described in subsection (b) of this section is not civilly liable for any act or omission in giving any assistance or medical care, if:

(1) The act or omission is not one of gross negligence;

(2) The assistance or medical care is provided without fee or other compensation; and

(3) The assistance or medical care is provided:

(i) At the scene of an emergency;

(ii) In transit to a medical facility; or

(iii) Through communications with personnel providing emergency assistance.

(b) *Applicability.* — Subsection (a) of this section applies to the following:

(1) An individual who is licensed by this State to provide medical care;

(2) A member of any State, county, municipal, or volunteer fire department, ambulance and rescue squad or law enforcement agency or of the National Ski Patrol System, or a corporate fire department responding to a call outside of its corporate premises, if the member:

(i) Has completed an American Red Cross course in advanced first aid and has a current card showing that status;

(ii) Has completed an equivalent of an American Red Cross course in advanced first aid, as determined by the Secretary of Health and Mental Hygiene; or

(iii) Is certified or licensed by this State as an emergency medical services provider;

(3) A volunteer fire department, ambulance and rescue squad whose members have immunity; and

(4) A corporation when its fire department personnel are immune under paragraph (2) of this subsection.

(c) *Immunity for individual not covered by this section.* — An individual who is not covered otherwise by this section is not civilly liable for any act or omission in providing assistance or medical aid to a victim at the scene of an emergency, if:

(1) The assistance or aid is provided in a reasonably prudent manner;

(2) The assistance or aid is provided without fee or other compensation; and

(3) The individual relinquishes care of the victim when someone who is licensed or certified by this State to provide medical care or services becomes available to take responsibility. (1982, ch. 770, § 4; ch. 775; 1983, ch. 248; 1997, ch. 14, § 9; ch. 201, § 2.)

Editor's note. — Section 9, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, transferred former § 5-309 of this article to be present § 5-603 of this article.

Section 2, ch. 561, Acts 1997, provides that "this Act is intended to clarify that an individual who is certified by the State as an emergency medical technician-paramedic, also known as an "EMT-P" or "paramedic", is entitled under § 5-309(b)(2)(iii) [now § 5-603(b)(2)(iii)] of the Courts Article to qualified immunity from civil liability for providing emergency assistance or medical care."

Maryland Law Review. — For comment, "Mercy Hosp. v. Jackson: A Recurring Dilemma for Health Care Providers in the Treatment of Jehovah's Witnesses," see 46 Md. L. Rev. 514 (1987).

For survey, "Developments in Maryland Law, 1990-91," see 51 Md. L. Rev. 507 (1992).

University of Baltimore Law Review. — For article, "Gross, Reckless, Wanton, and Indifferent: Gross Negligence in Maryland Civil Law," see 30 U. Balt. L. Rev. 1 (2000).

Construction of section. — Both the public official immunity and good Samaritan immunity are conditional, the former being conditioned on the absence of malice and the latter on the absence of gross negligence, and the existence vel non of those other factors are generally issues of fact to be determined at trial. Town of Port Deposit v. Petetit, 113 Md. App. 401, 688 A.2d 54 (1997).

Applicability of section. — Entitlement to the qualified immunity afforded by this section and § 5-309.1 [now § 5-604] of this article requires a finding that the defendant satisfies the conditions stated in the statutes, not the least of which is a conclusion that he falls within the enumerated categories of persons protected and that his alleged negligence does not amount to gross negligence. *Artis v.* Cyphers, 100 Md. App. 633, 642 A.2d 298, aff'd, 336 Md. 561, 649 A.2d 838 (1994).

Gross negligence not found. — Where the conduct of the paramedic and the police officer in treating decedent did not amount to gross negligence, they were immune from liability for death, and the trial court properly granted their motions for summary judgment. McCoy v. Hatmaker, 135 Md. App. 693, 763 A.2d 1233 (2000), cert denied, 364 Md. 141, 771 A.2d 1070 (2001).

Compensation. — Absent a charge to the victim by the person who is seeking immunity, salaried personnel do not receive "compensation" within the meaning of this section. Tatum v. Gigliotti, 80 Md. App. 559, 565 A.2d 354 (1989), aff'd, 321 Md. 623, 583 A.2d 1062 (1991).

The immunity provided by this section applies to a salaried emergency medical technician, acting within assigned duties, who does not charge a fee directly to the victim. Tatum v. Gigliotti, 321 Md. 623, 583 A.2d 1062 (1991).

Fee that does not fully compensate. — The fact that a fee charged by a municipality does not cover fully the City's expenses in providing such emergency services, and the fact that the fee does not result in a profit for the

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municipality, are irrelevant points for the purposes of construing the applicability of the statute to the action in question. Chase v. Mayor & City Council, 126 Md. App. 427, 730 A.2d 239 (1999), cert. granted sub nom. Baltimore v. Chase, 356 Md. 16, 736 A.2d 1064 (1999).

Fee not paid. — The fact that a fee charged was never actually paid is irrelevant for the purposes of construing the applicability of the statute to the action in question. Chase v. Mayor & City Council, 126 Md. App. 427, 730 A.2d 239 (1999), cert. granted sub nom. Baltimore v. Chase, 356 Md. 16, 736 A.2d 1064 (1999).

Fee charged for the transfer of a patient. — If the State Police charged a fee for the transfer of a patient from one hospital to another, the State Police employees involved in the transfer would no longer have immunity under this section. 76 Op. Att'y Gen. 95 (July 26, 1991).

The imposition of a fee by the State Police would not affect the immunity of persons employed by the hospitals involved or a shock trauma center. The question of their immunity under this section would depend on whether they or their employers charged a fee for their role in the transfer of the patient. 76 Op. Att'y Gen. 95 (July 26, 1991).

Because this section does not provide an exception for the "token" fee charged by a city for "transport" costs, as these costs are within the purview of medical services, charging such fees removes immunity under the statute for services rendered. Chase v. Mayor & City Council, 126 Md. App. 427, 730 A.2d 239 (1999), cert. granted sub nom. Baltimore v. Chase, 356 Md. 16, 736 A.2d 1064 (1999).

Fees for ambulance services not permitted. — A proposed ordinance establishing fees for ambulance services provided by the Annapolis Fire Department would jeopardize the immunity provided under this section, because the proposed ordinance would impose a fee on a victim for emergency assistance and medical care. 80 Op. Att'y Gen. 341 (June 9, 1995).

Immediate appeal from orders rejecting the immunity defense. — A trial court's denial of a claim of qualified immunity, to the extent that it turns on an issue of law, is immediately appealable. Artis v. Cyphers, 100 Md. App. 633, 642 A.2d 298, aff'd, 336 Md. 561, 649 A.2d 838 (1994).

Cited in Mayor & City Council v. Chase, 360 Md. 121, 756 A.2d 987 (2000).

§ 5-604. Fire and rescue companies.

(a) *Immunity from civil liability.* — Notwithstanding any other provision of law, except for any willful or grossly negligent act, a fire company or rescue company, and the personnel of a fire company or rescue company, are immune from civil liability for any act or omission in the course of performing their duties.

(b) *Waiver of immunity.* — (1) The immunity granted by this section is waived with respect to actions to recover damages for the negligent operation of a motor vehicle to the following extent:

(i) For a self-insured fire company or rescue company, liability shall extend up to the minimum insurance limits imposed by § 17-103 of the Transportation Article; and

(ii) For a fire company or rescue company insured by an insurer authorized to issue insurance policies in this State, liability shall extend up to the maximum limit of any basic vehicle liability insurance policy it has in effect, exclusive of excess liability coverage.

(2) The immunity granted by this section is not waived and may be raised as a defense as to any amount of damages claimed above the limits in this subsection and as to any other action for damages not involving the negligent operation of a motor vehicle. (1983, ch. 546; 1997, ch. 14, § 9.)

Editor's note. — Section 9, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, transferred former §§ 5-309.1 through 5-309.4 of this article to be present §§ 5-604 through 5-607 of this article, respectively.

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Maryland Law Review. — For article, "Survey of Developments in Maryland Law, 1986-87," see 47 Md. L. Rev. 739 (1988).

For survey, "Developments in Maryland Law, 1990-91," see 51 Md. L. Rev. 507 (1992).

Section not retroactive. — This section does not confer immunity for allegedly tortious conduct occurring prior to its effective date. Washington Sub. San. Comm'n v. Riverdale Heights Volunteer Fire Co., 308 Md. 556, 520 A.2d 1319 (1987).

Construction of section. — Both the public official immunity and good Samaritan immunity are conditional, the former being conditioned on the absence of malice and the latter on the absence of gross negligence, and the existence vel non of those other factors are generally issues of fact to be determined at trial. Town of Port Deposit v. Petetit, 113 Md. App. 401, 688 A.2d 54 (1997).

Applicability of section. — Entitlement to the qualified immunity afforded by this section and § 5-309 [now § 5-603] of this article requires a finding that the defendant satisfies the conditions stated in the statutes, not the least of which is a conclusion that he falls within the enumerated categories of persons protected and that his alleged negligence does not amount to gross negligence. Artis v. Cyphers, 100 Md. App. 633, 642 A.2d 298, aff'd, 336 Md. 561, 649 A.2d 838 (1994).

This statute applies to municipal fire and rescue departments and their employees, as well as to volunteer fire and rescue companies and their employees. Mayor & City Council v. Chase, 360 Md. 121, 756 A.2d 987 (2000).

State actor for purposes of 42 U.S.C. § 1983. — Based on the indicia of State involvement, the functions carried out by the actor, the nature of the relationship between the State and the actor, and the powers and authorities that had been conferred upon the actor by the State, a local Maryland volunteer fire company was a State actor for purposes of 42 U.S.C. § 1983. Goldstein v. Chestnut Ridge Volunteer Fire Co., 218 F.3d 337 (4th Cir. 2000).

Immediate appeal from orders rejecting the immunity defense. — A trial court's denial of a claim of qualified immunity, to the extent that it turns on an issue of law, is immediately appealable. Artis v. Cyphers, 100 Md. App. 633, 642 A.2d 298, aff'd, 336 Md. 561, 649 A.2d 838 (1994).

Stated in McCoy v. Hatmaker, 135 Md. App. 693, 763 A.2d 1233 (2000), cert denied, 364 Md. 141, 771 A.2d 1070 (2001).

Cited in Callahan v. Bowers, 131 Md. App. 163, 748 A.2d 499 (2000).

§ 5-605. Law enforcement officer acting outside jurisdiction.

(a) *When not civilly liable.* — A law enforcement officer acting outside the officer's jurisdiction but in the State, is not civilly liable, except to the extent that he would be if acting in his own jurisdiction, for any act or omission in preventing or attempting to prevent a crime, or in effectuating an arrest, in order to protect life or property if:

(1) The action is not grossly negligent; and

(2) The action is taken at the scene of the crime or attempted crime.

(b) *Defense by employer.* — A law enforcement officer sued for acting under subsection (a) of this section shall be defended in any civil action by the law enforcement officer's employer as if the incident had occurred in the officer's jurisdiction.

(c) *Benefits.* — A law enforcement officer who is injured in taking action under subsection (a) of this section is entitled to workers' compensation, disability, death benefits, life insurance and all other benefits to the same extent as if the injury had been sustained in the officer's jurisdiction. (1984, ch. 766; 1991, ch. 21, § 3; 1997, ch. 14, § 9.)

Editor's note. — Section 9, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, transferred former §§ 5-309.1 through 5-309.4 of this article to be present §§ 5-604 through 5-607 of this article, respectively.

Off-duty intervention in a felony. — Although a police officer was off duty and outside of his jurisdiction when he was confronted with two armed robbers, he was still authorized and required to uphold the laws of the State of Maryland; thus, the trial court was correct in

I also agree, however, that the Court need not decide that issue, because the State is unable to demonstrate that the trier of fact, in this case the trial judge, did not rely upon the defendant's conduct in shooting Stamidis as evidence of the requisite force or threat of force in finding the defendant guilty of robbery. As noted above, the trial judge need not have relied upon that evidence. If he believed that the defendant held Stamidis at gun point thereafter, that conduct alone would suffice to prove the "force" element of the robbery. But, in the absence of an affirmative showing that this was the rationale employed by the trial judge, the Court cannot assume that it was. *Nightingale v. State*, 312 Md. 699, 542 A.2d 373 (1988); *State v. Frye*, 283 Md. 709, 393 A.2d 1372 (1978).

Chief Judge MURPHY has authorized me to state that he joins in this concurring opinion.

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583 A.2d 1062

Elizabeth TATUM, et al.

v.

Gregory GIGLIOTTI, et al.

No. 162, Sept. Term, 1989.

Court of Appeals of Maryland.

Jan. 14, 1991.

Representative of patient who died during asthma attack brought wrongful death and survival action against emergency medical technicians and county. The Circuit Court, Prince George's County, James Magruder Rea, J., dismissed claims against county and one technician and entered judgment for remaining technician after jury was unable to reach verdict. Appeal was taken. The Court of Special Appeals, 80 Md.App. 559, 565 A.2d 354, affirmed.

Request for writ of certiorari was granted. The Court of Appeals, Cole, J., retired, held that: (1) immunity provided by Good Samaritan statute applied to salaried emergency medical technician, and (2) gross negligent standard of Good Samaritan statute applied to actions by technician.

Affirmed.

1. Statutes ⇐188

Words of statute are to be given their ordinary signification absent manifest contrary intent on part of legislature.

2. Counties ⇐88

Good Samaritan statute, granting immunity from liability to emergency medical technicians who render medical care at scene of emergency or in transit to medical facilities, applied to salaried member of county ambulance or rescue squad, as well as to volunteers. Code 1957, Art. 43, § 132 (Repealed); Code, Courts and Judicial Proceedings, § 5–309.

3. Physicians and Surgeons ⇐16

Salaried emergency medical technician (EMT), operating within scope of duty in providing emergency care to patient suffering asthma attack, was subject to gross negligent standard of care in Good Samaritan statute, and, thus, EMT was immune from liability even if treatment provided patient was ordinarily negligent.

David J. Perrone (Thomas Fortune Fay, Clower and Fay, P.C., all on brief), Washington, D.C., for petitioners.

Michael O. Connaughton, Deputy County Atty. (Michael P. Whalen, County Atty., J. Michael Dougherty, Jr., Associate County Atty., all on brief) Upper Marlboro, for respondents.

Argued before MURPHY, C.J., ELDRIDGE, RODOWSKY, McAULIFFE and CHASANOW, JJ., and COLE,* Associate Judge of the Court of Appeals (retired).

COLE, Judge.

In this case we shall decide whether the Maryland Good Samaritan statute applies to a salaried Emergency Medical Technician (EMT) operating within the scope of his duties. The question presented arises on the grant of a motion for judgment. Therefore, we state the facts most favorable to the plaintiff.

Petitioner's son, Norman Tatum, Jr. (Tatum), had suffered from moderate to severe asthma since the age of three. At approximately 1:00 a.m. on September 21, 1981, Tatum experienced an asthma attack and called the Prince George's County Fire Department for assistance. He informed the dispatcher that he was having a severe asthma attack. Respondents, Gregory Gigliotti and Richard Miller, both EMTs for the Prince George's County Fire Department, responded to the call and attempted to treat Tatum.

They attempted to place a paper bag over his face as treatment for hyperventilation, although that act was in contravention of the prescribed treatment for an asthma attack. The EMTs assisted Tatum as he walked down the twelve flights of stairs to reach the ambulance, but they did not carry him on a stretcher, even though he was having great difficulty breathing. In the ambulance, Gigliotti attempted to place an oxygen mask over Tatum's face, but the latter struggled against that action and would not allow it. At some point, on the way to the hospital Tatum fell off the ambulance bench onto the floor of the vehicle. He was

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* Cole, J., now retired, participated in the hearing and conference of this case while an active member of this Court; after being recalled pursuant to the Constitution, Art. IV, Sec. 3A, he also participated in the decision and the adoption of this opinion.

lying face down on the floor when the ambulance arrived at the hospital.

Gigliotti's ambulance report indicated that Tatum arrived at the hospital in stable condition, but that diagnosis was contradicted by the emergency room nurse who testified that Tatum had been in complete respiratory and cardiac arrest upon his arrival at the hospital. Efforts to revive him were unsuccessful. The doctor who performed the autopsy testified that severe oxygen deprivation was the cause of Tatum's death.

Petitioner, Tatum's mother, brought a wrongful death and survival action against Gigliotti, Miller, and Prince George's County. The actions against Miller and Prince George's County were dismissed before trial commenced. At the conclusion of the jury trial against Gigliotti, the jury, after deliberating for more than twelve hours, informed the judge that it was deadlocked. The court declared a mistrial. It also granted the Respondent's motion for judgment on the ground that the Good Samaritan statute applied to Gigliotti, thereby requiring proof that he was grossly negligent.[1]

In 1981, the year of Tatum's death, the Good Samaritan statute provided in pertinent part:

"§ 132. Liability for civil damages of physicians, nurses and certain other persons rendering aid under emergency conditions.

(a) A person licensed by the State of Maryland to provide medical care, who renders medical aid, care, or assistance for which he charges no fee or compensation: (1) at the scene of an emergency; (2) in transit to medical facilities; or (3) through communications with personnel rendering emergency assistance is not liable for any civil damages as the result of any professional act or omission by him not amounting to gross negligence.

1. Whether Petitioner's proof, related above, satisfies the statute's gross negligence standard is an issue that is not before us.

(b) A member of any State, county, municipal or volunteer fire department, ambulance and rescue squad, or the National Ski Patrol System, or law enforcement agency who has completed an American Red Cross course in advanced first aid or its equivalent and possesses a current card indicating that status as determined by the Secretary of Health and Mental Hygiene, or is certified by the State of Maryland as an emergency medical technician or cardiac rescue technician has the same immunity provided in subsection (a). A volunteer fire department or ambulance and rescue squad has the same immunity as its members.

(c) Members and employees of federal, State, county, or city governments, hospitals, emergency medical service councils and agencies which operate as nonprofit groups that provide support to the emergency medical system through the provision of care, equipment, facilities, or consultant support without charging the emergency victim a fee for the service provided are not liable for any civil damages resulting from acts or omissions not amounting to gross negligence."

Md.Code (1957, 1980 Repl.Vol.), Art. 43, § 132.[2]

Petitioner appealed to the Court of Special Appeals which affirmed. *Tatum v. Gigliotti*, 80 Md.App. 559, 565 A.2d 354 (1989). The intermediate appellate court held that the immunity provided by the statute applies to a salaried EMT, acting within assigned duties, who does not charge a fee directly to the victim. We granted Petitioner's request for the writ of certiorari.

Beyond recognizing that § 132 does not impose upon anyone an affirmative duty to render assistance to one in need, *Pope v. State*, 284 Md. 309, 325, 396 A.2d 1054, 1064 (1979), this Court has not had an opportunity to interpret the Good Samaritan statute. The Court of Special Appeals has, however, stated in dicta that volunteer firemen are

2. The statute, as subsequently recodified, is now Md.Code (1974, 1989 Repl.Vol.), § 5-309 of the Courts and Judicial Proceedings Article.

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immune from ordinary civil liability for any act or omission in rendering emergency medical assistance. *Utica Mut. Ins. Co. v. Gaithersburg–Washington Grove Fire Dep't*, 53 Md.App. 589, 595 n. 5, 455 A.2d 987, 991 n. 5, *cert. denied*, 296 Md. 224 (1983). The Attorney General also addressed the issue and stated:

> "The whole statutory scheme reflects the principle that, if the victim is charged for the help by the person seeking immunity, then no immunity is available under the Good Samaritan Law; but, if the victim is not charged by the one rendering the assistance and seeking immunity, then even a salaried employee is entitled to immunity absent gross negligence."

64 Op. Att'y Gen. 175, 177 (1979) (footnote omitted).

[1] We first note that as a general principle of statutory construction the words of a statute are to be given their ordinary signification absent a manifest contrary intent on the part of the legislature. Results inconsistent with common sense are to be avoided. *See Kaczorowski v. City of Baltimore*, 309 Md. 505, 525 A.2d 628 (1987). *See also Harford County v. University of Maryland Medical Sys.*, 318 Md. 525, 529, 569 A.2d 649, 651 (1990); *Potter v. Bethesda Fire Dep't, Inc.*, 309 Md. 347, 524 A.2d 61 (1987). Moreover, we have recognized that statutes are to be " 'construed reasonably, with reference to the purpose to be accomplished....' " *Potter*, 309 Md. at 353, 524 A.2d at 64 (quoting *State v. Fabritz*, 276 Md. 416, 421, 348 A.2d 275, 278 (1975), *cert. denied*, 425 U.S. 942, 96 S.Ct. 1680, 48 L.Ed.2d 185 (1976)).

Petitioner's argument rests primarily on subsection (a) of § 132. She contends that, because Gigliotti was paid a salary by Prince George's County, he was not a person who rendered assistance without charging "compensation." Petitioner further argues that Good Samaritan statutes do not apply to one who is under a pre-existing duty to render medical assistance. In the latter respect Petitioner relies upon a line of cases led by *Lee v. State*, 490 P.2d 1206 (Alaska 1971), which reasoned that the purpose of a Good

Samaritan statute is to "induce voluntary rescue by removing the fear of potential liability which acts as an impediment to such rescue." *Id.* at 1209. And *see Colby v. Schwartz*, 78 Cal.App.3d 885, 144 Cal.Rptr. 624 (1978); *Henry v. Barfield*, 186 Ga.App. 423, 367 S.E.2d 289 (1988); *Clayton v. Kelly*, 183 Ga.App. 45, 357 S.E.2d 865 (1987); *Tiedeman v. Morgan*, 435 N.W.2d 86 (Minn.App.1989); *Lindsey v. Miami Dev. Corp.*, 689 S.W.2d 856 (Tenn.1985).

[2, 3] We, however, find those cases to be inapposite. We are unpersuaded by the out-of-state authority because we cannot overlook the clear language of our § 132(b) which distinguishes the Maryland statute from the statutes interpreted in the cases previously cited. Subsection (b) expressly applies to "member[s] of ... county ... ambulance and rescue squad[s] ... certified ... as [ ] emergency medical technician[s]" who render medical care at the scene of an emergency or in transit to medical facilities. Respondent clearly falls within this description. The General Assembly certainly knew that "[a] member of [a] county ... ambulance or rescue squad" has a pre-existing duty to provide medical care and, typically, is salaried. Accordingly, rather than exclude from coverage those EMTs, the statute clearly extends immunity to them.

The legislative history reinforces this conclusion. Maryland's Good Samaritan statute was first enacted by Ch. 65 of the Acts of 1963. Originally limiting coverage to physicians licensed to practice medicine, the statute provided doctors protection against civil liability for acts or omissions not amounting to gross negligence and for which the physician received no fee or compensation from the patient for rendering the aid. In 1964 the law was amended by Ch. 48 to include trained "members of volunteer ambulance and rescue squads." The next year a third section was added providing the same immunity to registered nurses and licensed practical nurses. *See* 1965 Md.Laws, Ch. 475. By Ch. 616 of the Acts of 1969, the legislature again amended the statute and extended coverage to include trained "members or employees of fire departments." More important,

the legislature deleted the word "volunteer" that had preceded "ambulance and rescue squads" in the 1964 version of the statute. Between 1970 and 1976 other provisions were added to the statute. In 1976 the legislature repealed and reenacted the law, consolidating its provisions into four subsections, the first three of which have been reproduced above. See 1976 Md.Laws, ch. 689. Thus, the immunity is granted to, *inter alia*, members of fire departments and ambulance and rescue squads which may be state, county or municipal, as well as volunteer.

We hold that the gross negligence standard of the Good Samaritan statute was the proper standard to be applied by the courts below.

JUDGMENT OF THE COURT OF SPECIAL APPEALS AFFIRMED. COSTS TO BE PAID BY THE PETITIONER.

TORTS

IMMUNITY – EFFECT OF FEES CHARGED BY MUNICIPAL AMBULANCE SERVICE ON GOOD SAMARITAN LAW IMMUNITY

June 9, 1995

The Honorable Alfred A. Hopkins
Mayor of Annapolis

You have requested our opinion whether a proposed ordinance establishing fees for ambulance services provided by the Annapolis Fire Department would jeopardize the immunity provided under §5-309 of the Courts and Judicial Proceedings ("CJ") Article, Maryland Code.

For the reasons stated below, we conclude that, because the proposed ordinance would impose a fee on a victim for emergency assistance and medical care, enactment of the ordinance would result in the loss of immunity under CJ §5-309.

I

The Proposed Ordinance

Under current city law, a $25 fee is charged when an ambulance is used "for routine transportation for nonemergency service." §2.32.110 of the Annapolis City Code. The full text of this provision is as follows: "An ambulance generally shall not be used for routine transportation for nonemergency service, but when the service is provided the fee shall be twenty-five dollars."

Ordinance No. O-81-94 was introduced for "the purpose of revising the fees for ambulance service." The ordinance would charge fees "to any person who utilizes ambulance services provided by the Annapolis Fire Department." The fee would be $100 "for basic life support ... transport and all other ambulance services other than advance life support ... transports." The fee would be $290 if the transport involved advanced life support.

Both basic life support and advance life support, as defined in the proposed ordinance, involve the provision of emergency medical care. Basic life support includes "patient assessment, control of bleeding, splinting of fractures, treatment of shock, spinal immobilization, oxygen administration, CPR, obstetrical delivery, and the management of medical and environmental emergencies." Advance life support includes all of these services plus "administration of medication, intravenous fluids, cardiac monitoring, telemetry, cardiac defibrillation, endotracheal intubation, relieving pneumothorax conditions and other advanced techniques as approved by the Maryland Board of Physician Quality Assurance."

The proposed ordinance imposes on the City's Director of Finance the responsibility to collect the fees.[1] All of the fees "shall be used to support the City of Annapolis Emergency Medical Services."

II

Fees For Emergency Services and Immunity Under CJ §5-309

The current version of Maryland's original "Good Samaritan" immunity provision is set out in CJ §5-309(a):

> A person described in subsection (b) of this section is not civilly liable for any act or omission in giving any assistance or medical care, if:
>
> (1) The act or omission is not one of gross negligence;
>
> (2) The assistance or medical care is provided without fee or other compensation; and
>
> (3) The assistance or medical care is provided:

[1] The Director may waive a fee "upon satisfactory proof of indigency."

> (i) At the scene of the emergency;
>
> (ii) In transit to a medical facility; or
>
> (iii) Through communications with personnel providing the emergency assistance.

This immunity applies to municipal ambulance personnel, among others. CJ §5-309(b)(2). *See also* CJ §5-310 (affording immunity to governmental personnel who provide "support to the emergency medical system by giving care, equipment, facilities, or consultation, if, among other things, "[t]he service is provided without fee to the emergency victim"). The reference to emergency assistance or medical care "provided without fee or other compensation" is derived from the original Good Samaritan law, then applicable only to physicians. *See* Chapter 65 of the Laws of Maryland 1963.

The only completely settled issue regarding the "no compensation" provision is "that absent a charge to the victim by the person who is seeking immunity, salaried personnel do not receive 'compensation' within the meaning of this section." *Tatum v. Gigliotti*, 80 Md. App. 559, 568, 565 A.2d 354 (1989), *aff'd*, 321 Md. 623, 583 A.2d 1062 (1991). Thus, a salaried paramedic was entitled to assert immunity under what is now CJ §5-309.

This office has addressed the effect of fees on immunity several times. A 1976 letter[2] discussed "the status of volunteer fire company and/or rescue squad personnel under the State's revised Good Samaritan Laws in situations where a charge is imposed for ambulance services." The statute at the time granted immunity for emergency "medical aid, care, or assistance" for which the provider charged "no fee or compensation." Former Article 43, §132(a). The 1976 letter differentiated between a fire company's charge for the use of its ambulance, which would not lead to the loss of individual immunity, and a charge for the medical services, which would:

> In our view, [the pertinent language] means that no charge may be imposed for the aid, care or assistance which the individual

[2] Under the practice at the time, this letter was labeled an "Opinion of the Attorney General," although only a single Assistant Attorney General signed it; the Attorney General did not. Opinion No. 76-167 (September 16, 1976) (unpublished). Such a letter would not be regarded as an Opinion of the Attorney General under current practice.

> provides in order for him to be protected. We do not believe that his individual protection would be lost, however, simply because the fire company or rescue squad imposes a charge for the use of its ambulance so long as no charge is imposed by the individual or the agency for the aid received from the individual seeking protection of the statute.

Opinion No. 76-167, at 2. This portion of the 1976 letter rested on a precarious premise: that the "use of [an] ambulance" is distinct from "medical aid, care, or assistance," for purposes of cost-shifting. The letter did not explain why the use of an ambulance to provide speedy transportation to a hospital is not itself part of "medical ... assistance" in an emergency, nor did it explain how a cost component for ambulance use can be separated from the overall cost of providing a range of pre-hospital care.

In 1979, Attorney General Sachs issued the first true Opinion of the Attorney General on this subject. The opinion concluded that immunity under the predecessor of CJ §5-309 was not lost merely because an ambulance company paid a salary to its paramedics. 64 *Opinions of the Attorney General* 175 (1979).[3] As the opinion explained, "the whole statutory scheme reflects the principle that, if the victim is charged for the help by the person seeking immunity, then no immunity is available under the Good Samaritan Law; but, if the victim is not charged by the one rendering the assistance and seeking immunity, then even a salaried employee is entitled to immunity absent gross negligence." 64 *Opinions of the Attorney General* at 177.

The opinion went on to assume, without further analysis, that the 1976 letter was correct in its treatment of certain charges imposed by a rescue squad: "Indeed, a member of a volunteer rescue squad – as distinguished from the squad itself – would be entitled to immunity even if, for example, the rescue squad imposes a charge to cover the costs and expenses incurred by it." *Id.*[4] The opinion elaborated as follows:

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[3] This conclusion was later affirmed in *Tatum v. Gigliotti.*

[4] We take it that the phrase "costs and expenses" was intended to be synonymous with the earlier letter's phrase, "a charge for the use of [the] ambulance."

> We understand that no charge is imposed by the members of the squad who render assistance and that the only charge made by the squad is for reimbursement of the costs incurred by the squad in providing its services. We assume, therefore, that the system of charges by the squad is not designed to compensate any of its members for their role in rendering the assistance in question, *nor does it include any fee (beyond a charge for costs and expenses incurred) for the emergency assistance itself.*

64 *Opinions of the Attorney General* at 179 n.6 (emphasis added).

In 1987, this office once again revisited the issue of fees. In Opinion No. 87-055 (November 17, 1987) (unpublished), the issue was "whether CJ §5-309 applies to volunteer firemen who operate an ambulance service and who receive monetary consideration for their services. This issue also gives rise to the related question of whether CJ §5-309 applies to a fire company or rescue squad that itself receives monetary consideration for its services." Opinion No. 87-055, at 1.

The opinion reaffirmed Attorney General Sach's conclusion (later endorsed in *Tatum v. Gigliotti*) that a payment of compensation to the members of the volunteer company would not forfeit immunity: "This interpretation of the compensation requirement renders CJ §5-309 applicable to ambulance service personnel receiving stipends from local fire departments or municipalities, assuming that they satisfy the other statutory conditions for immunity. The Good Samaritan Law would protect them regardless of whether their stipends were intended as cost reimbursements, as long as the stipends did not come from the recipients of their services." Opinion No. 87-055, at 4.

The 1987 opinion then went on to conclude that "ambulance companies charging membership fees and billing nonmembers for individual calls do not qualify for immunity under CJ §5-309.... CJ §5-309 does not apply to a company if its fees are collected directly from the recipients of the ambulance services." *Id.* In its statement of the factual background, the opinion described certain ambulance companies as "offer[ing] residents of a service area the option of paying an annual membership fee or paying for individual ambulance calls." Opinion No. 87-055, at 2. The opinion did not

attempt to differentiate, as had the 1976 letter and the 1979 opinion, between the portion of the fee attributable to medical care and the portion attributable to the use of the ambulance. If an ambulance company charged the fee, the opinion concluded, the company would lose its immunity.[5]

Finally, a 1991 opinion suggested that "the charging of a fee makes Good Samaritan immunity unavailable to the employees of an organization that charges a fee." 76 *Opinions of the Attorney General* 95, 102 (1991). This last opinion did not attempt to parse the nature of the "fee" that would result in the loss of immunity.

The 1987 and 1991 opinions did not pursue the distinction first drawn in the 1976 letter for a good reason: There are significant conceptual and practical problems in attempting to distinguish between a fee for the use of an ambulance as a mode of transportation and a fee for "assistance or medical care." When emergency medical services personnel respond to an emergency call, they provide both "medical care" to stabilize the victim and "assistance" in the form of fast transportation to an emergency room or trauma center.[6] The very act of transporting a victim in an emergency appears to be "assistance" that is to be rendered "without fee or compensation." CJ §5-309(a)(2).

Moreover, even if the transportation component of emergency ambulance service were outside the Good Samaritan Law's ban on charging fees, as a practical matter reckoning the fee without being arbitrary would be difficult. How would one calculate, for example, the portion of salary or equipment costs that is attributable to the use of the ambulance but not the emergency assistance?

Given the terms of Ordinance No. O-81-94, however, we need not consider whether an ambulance service could ever successfully thread the needle of cost-shifting under CJ §5-309: that is, retain Good Samaritan immunity under CJ §5-309 while charging some

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[5] Nevertheless, the opinion suggested that the charging of these fees might not "preclud[e] the squad's individual members from qualifying for immunity." Opinion No. 87-055, at 5 n.4.

[6] Precisely because speedy transportation is crucial to the medical well-being of the victim, the personnel who drive an ambulance are given the privilege to ignore otherwise applicable vehicle laws. *See* §§21-106 and 22-218(c) of the Transportation Article, Maryland Code.

costs to the victim. The proposed ordinance surely does not do so. Under any analysis, the charges contemplated by the ordinance exceed those reasonably related to the mere use of the ambulance and instead cover the cost of the emergency medical services provided to the patient while at the scene or en route. This medical care would not be provided "without fee or compensation," and the immunity would be lost.

III

Scope of Immunity Under CJ §5-309.1

A subsequently enacted immunity provision, CJ §5-309.1(a), provides as follows: "Notwithstanding any other provision of law, except for any willful or grossly negligent act, a fire company or rescue company, and the personnel of a fire company or rescue company, are immune from civil liability for any act or omission in the course of performing their duties." As we stated in a prior opinion, "this grant of immunity imposes no conditions with respect to receipt of any type of compensation." Opinion No. 87-055, at 6. If CJ §5-309.1 were applicable to municipal fire departments, the issue posed in your request – the effect on immunity under CJ §5-309 of compensation for emergency medical services – would be moot.

The City Attorney has expressed doubt, however, that CJ §5-309.1 applies to municipal fire departments, and we share that doubt. As we discussed in our prior opinion, "[t]he history of [CJ §5-309.1] indicates that it constituted the legislative response to a decision by the Court of Special Appeals holding that volunteer fire companies are not considered governmental entities entitled to immunity, and that volunteer firemen are not public officials for the purpose of qualified immunity." Opinion No. 87-055, at 6 n.6. When the bill was introduced, it expressly limited the grant of immunity to "volunteer" fire companies. *See* Senate Bill 731 of the 1983 Session. According to the hearing summary of the Senate Judicial Proceedings Committee, "the purpose of this bill is to protect volunteer fire departments from liability arising from suits which do not involve acts of gross negligence." The committee then adopted an amendment that deleted the original provisions and extended the immunity to fire and rescue companies, without the modifier "volunteer." Nevertheless, even after the amendment, the committee identified the "background" problem as the fact that "few people would volunteer to serve the fire departments, if they realized that

they could be subject to liability for their acts." Furthermore, the bill as enacted contained language relating to the negligent operation of motor vehicles that suggests a focus on non-governmental fire and rescue companies.

Perhaps the courts will give substantial weight to the deletion of the term "volunteer" and hold CJ §5-309.1 to be applicable to governmental fire and rescue companies. *See Tatum v. Gigliotti*, 321 Md. at 629-30. However, the context suggests otherwise. Given these doubts about the applicability of CJ §5-309.1 to a municipal fire department, the City would be taking a significant risk were it to rely on immunity under this section as a basis for proceeding with Ordinance O-81-94.

IV

Conclusion

In summary, it is our opinion that, because Ordinance No. O-81-94 imposes fees for emergency assistance and medical care, the ordinance would jeopardize the immunity otherwise afforded under CJ §5-309.[7]

J. Joseph Curran, Jr.
Attorney General

Jack Schwartz
Chief Counsel
Opinions & Advice

Editor's Note:

The provisions discussed in this opinion have been recodified within the Courts Article. Former §5-309 is now §5-603. Former §5-309.1 is now §5-604. The latter provision was held by the Court of Appeals to be applicable to municipal fire department personnel. *Mayor & City Council of Baltimore v. Chase*, 360 Md. 121, 756 A.2d 987 (2000).

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[7] We have not been asked, and therefore do not address, questions of immunity or liability under the Local Government Tort Claims Act, CJ Title 5, Subtitle 4. Nor do we express a view concerning immunity in relation to the current ambulance fee ordinance in Annapolis. *See* Part I above.

756 A.2d 987

MAYOR AND CITY COUNCIL OF BALTIMORE, et al.

v.

Sharon E. CHASE, Personal Representative of the Estate of Carlean Burley, et al.

No. 77, Sept. Term, 1999.

Court of Appeals of Maryland.

July 27, 2000.

Reconsideration Denied Aug. 21, 2000.

Patient's estate sued city and paramedic for city fire department, alleging that paramedic negligently intubated patient while attempting to resuscitate her during cardiac arrest, thereby directly and proximately causing her death. The Circuit Court, Baltimore City, David B. Mitchell, J., granted summary judgment for paramedic and city. Estate appealed. The Court of Special Appeals, Harrell, J., 126 Md.App. 427, 730 A.2d 239, reversed and remanded, and appeal was taken. The Court of Appeals, Bell, C.J., held that Fire and Rescue Company Act, which provides immunity to fire and rescue departments for any act or omission in course of performing their duties, with exception of willful or grossly negligent acts, applies to municipal fire and rescue departments and their employees, as well as to volunteer fire and rescue companies and their employees.

Reversed and remanded with directions.

Raker, J., dissented and filed opinion in which Eldridge and Wilner, JJ., joined.

1. **Municipal Corporations** ⇐747(3, 4)

Fire and Rescue Company Act, which provides immunity to fire and rescue departments for any act or omission in course of performing their duties, with exception of willful or grossly negligent acts, applies to municipal fire and rescue departments and their employees, as well as to volunteer fire

and rescue companies and their employees. Code, Courts and Judicial Proceedings, § 5–604(a).

2. Statutes ⇐181(1)

Goal with which court approaches the interpretation of a statute is to determine the intention of the legislature in enacting it.

3. Statutes ⇐190

Statute whose terms are unambiguous when the statute is considered by itself may be rendered ambiguous when viewed in light of a related statute or when that statute is part of a larger statutory scheme.

4. Statutes ⇐217.4

Resort to legislative history is a confirmatory process; it is not undertaken to contradict the plain meaning of the statute.

Timothy L. Mullin, Jr. (Edward W. Brady, Alicia C. Reynolds, Miles & Stockbridge, P.C., on brief), Baltimore, for petitioners.

John Amato, IV (Goodman, Meagher & Enoch, LLP, on brief), Baltimore, for respondents.

Thomas A. Woodley, Kurt T. Rumsfeld, Manar S. Morales, Mulholland & Hickey, Washington, DC, on brief of Amici Curiae International Ass'n of Fire Fighters, AFL-CIO, and other named organizations on behalf of Appellants.

Joel A. Smith, Linda Cortez, Kahn, Smith & Collins, P.A., Baltimore (counsel for Amici Curiae, Maryland State & District of Columbia Professional Firefighters, AFL-CIO, CLE, et al.), on briefs on behalf of Amici Curiae, Maryland State and District of Columbia Professional Fire Fighters, AFL-CIO-CLC; Baltimore City Fire Fighters, Local 734; Baltimore City Fire Officers, Local 964; Baltimore County Professional Fire Fighters Ass'n, Local 1311; Anne Arundel County Professional Fire Fighters, Local 1563; Hagerstown Professional Fire Fighters, Local 1605; Prince George's County Fire Fighters, Local 1619; Montgomery County Career Fire Fighters, Local 1644; Cumberland Fire Fighters, Local 1715; BWI Airport Fire Fighters, Local 1742; Annapolis Professional Fire Fighters, Local 1926; Howard County Professional Fire Fighters, Local 2000 and Career Firefighters Ass'n of Frederick County, Local 3666.

Argued before BELL, C.J., and ELDRIDGE, RODOWSKY, RAKER, WILNER, CATHELL and ROBERT L. KARWACKI, (Retired, Specially Assigned), JJ.

BELL, Chief Judge.

[1] The issue that we resolve in this opinion is the applicability of Maryland Code (1973, 1998 Repl.Vol., 1999 Cum Supp.) § 5–604(a),[1] which grants immunity to those within its coverage "from civil liability for any act or omission in the course of performing their duties," to a paramedic in the Baltimore City Fire Department. Consistent with the conclusion reached by the Circuit Court for Baltimore City and contrary to that of the Court of Special Appeals, *see Chase v. Mayor & City Council of Baltimore*, 126 Md.App. 427, 441–44, 730 A.2d 239, 246–48 (1999), we shall hold that this statute applies to municipal fire and rescue departments and their employees, as well as to volunteer fire and rescue companies and their employees. Accordingly, we reverse the judgment of the intermediate appellate court.[2]

Kevin D. Williams, one of the petitioners, is an emergency medical technician, a paramedic, employed by the Baltimore

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1. Maryland Code (1973, 1998 Repl.Vol., 1999 Cum.Supp.) § 5–604(a) of the Courts and Judicial Proceedings Article provides:

"(a) Immunity from civil liability.—Notwithstanding any other provision of law, except for any wilful or grossly negligent act, a fire company or rescue company, and the personnel of a fire company or rescue company are immune from civil liability for any act or omission in the course of performing their duties."

2. Included in the Petition for Writ of Certiorari, which we granted, was a second question, i.e.,

"Whether a paramedic employed by the Baltimore City Fire Department to provide emergency medical services is denied immunity under Section 5–603 of the Courts and Judicial Proceedings Article because the City of Baltimore charges a fee for transportation to a hospital by a Baltimore City Fire Department ambulance."

City Fire Department. In the performance of his duties, the petitioner, along with the ambulance driver responded to a 911 call for ambulance. Upon arrival at the address from which the call was made, he met the patient, Carlean Burley, the respondents'[3] decedent. After her condition had been assessed and oxygen administered, the patient was placed in the ambulance for transport to the hospital. When the patient went into cardiac arrest, the petitioner, as a part of emergency treatment, attempted to intubate her—a procedure in which a tube is put into the treachea to assist in breathing. The patient was then transported to the hospital, where she died the next day.

The respondents filed suit in the Circuit Court for Baltimore City against the Mayor and City Council of Baltimore and the petitioner Kevin Williams, alleging that Williams improperly intubated Ms. Burley by inserting the tube in her esophagus instead of her trachea. They further alleged that the error was negligence and gross negligence and that it caused her death. Following a hearing, the Circuit Court granted summary judgment in favor of the petitioners, holding, *inter alia*, that § 5–604 was applicable, that the conduct of petitioner Williams was not grossly negligent and, as a result, that both Williams and the City were immune from civil liability. The respondents successfully appealed to the Court of Special Appeals. That court held that § 5–604 applied only to volunteer and private fire and rescue companies and their personnel and, therefore, was inapplicable to a paramedic employed by a municipal fire department.[4] 126 Md.App. at 442–44, 730 A.2d at 247–48.

We need not now reach that issue and, therefore, neither intimate, nor express any opinion as to its answer.

3. Sharon E. Chase, personal representative of the estate of Carlean Burley, and Darlene Burley, guardian and next friend of Richard Sturdivant, grandson of Ms. Burley, on whom, it was alleged, he was financially dependent.

4. The Court of Special Appeals also addressed the petitioners' entitlement to immunity under The Good Samaritan Act, Maryland Code (1973, 1998 Repl.Vol., 1999 Cum.Supp.) § 5–603 of the Courts and Judicial Proceedings Article. It concluded that statute did not immunize a paramedic employed by a municipal fire department when the city charges a fee for ambulance service. *Chase v. Mayor and City Council of Baltimore*, 126 Md.App. 427, 437–40, 730 A.2d 239, 244–46 (1999). As previously indicated, we do not reach this issue.

Since this case is about the meaning and, thus, the effect, of § 5–604, it is governed by well settled canons of statutory construction. The legislative history of Senate Bill 731, which became the Fire and Rescue Act, Maryland Code (1973, 1983 Replacement Volume) § 5–309.1 of the Courts and Judicial Proceedings Article, *see* 1983 Laws, ch. 546, the predecessor of § 5–604 is confirmatory of the meaning discerned from the words of the statute itself. Section 5–604 has been before this Court previously for interpretation, but not on this issue.

In *Washington Suburban Sanitary Commission v. Riverdale Heights Volunteer Fire Co., Inc.*, 308 Md. 556, 569, 520 A.2d 1319, 1326 (1987), we considered the legislative history of § 5–604, noting that it was before the General Assembly during the 1983 session and that:

> "The file of the Senate Judicial Proceedings Committee ... reflects that the legislation was a response to *Utica Mutual Insurance Co., Inc. v. Gaithersburg–Washington Grove Fire Department, Inc.*, 53 Md.App. 589, 455 A.2d 987 (1983). Utica Mutual was a negligence action brought by a fire insurance company, as subrogee of its insured, against a fire company for alleged negligence in failing properly to extinguish a fire which later reignited leading to a second fire. The circuit court had held that the fire company enjoyed governmental immunity but the Court of Special Appeals reversed, holding that whether a fire company enjoyed governmental immunity was a question of fact on which the fire company in *Utica Mutual* had failed to produce sufficient evidence. The intermediate appellate court decided *Utica Mutual* on February 2, 1983, and on February 3, 1983, a member of the Maryland Senate requested the Department of Legislative Reference to prepare a bill granting immunity to volunteer

firefighters. As introduced the bill provided that '[a] volunteer fire company is immune from liability in the same manner as a local government agency for any act or omission in the course of performing its duties if [ ] the act or omission is not one of gross negligence....' The bill was amended in the course of passage to its present form."

Because the issue presented in that case was the retrospective application of the statute, we contented ourselves with rejecting the Fire Company's argument that its purpose was to restore the governmental immunity volunteer companies enjoyed before the *Utica* decision. *Id.* at 570, 520 A.2d at 1326–27. Thus, although we noted the statute's genesis and its metamorphosis during its trek through the legislative process, we did not address the statute's meaning, applied prospectively, and, indeed, had no need to do so.

Nevertheless, from the standpoint of statutory construction, it is important that the statute started with a narrow focus—to exempt volunteer fire companies—and ended worded much more broadly—referring simply to "a fire company or rescue company, and the personnel of a fire company or rescue company." That most emphatically supports the argument that the petitioners make, that the Legislature, by enacting the statute, intended to immunize all fire and rescue companies and their personnel and that immunization is "from civil liability for any act or omission in the course of performing their duties." In point of fact, the statute in this regard is quite clear and unambiguous. Reading the statute reveals not a bit of ambiguity as to the scope of its reach and, giving the words of the statute their ordinary meaning, as we are required to do, *see Chesapeake and Potomac Telephone Co. of Maryland v. Director of Finance for Mayor and City Council of Baltimore*, 343 Md. 567, 578, 683 A.2d 512, 517 (1996) ("we begin our inquiry with the words of the statute and, ordinarily, when the words of the statute are clear and unambiguous, according to their commonly understood meaning, we end our inquiry there also"), even less as to its clarity. The statute is rendered even clearer when it is recalled that the Legislature

knows how to differentiate between voluntary fire companies and municipal fire companies and has done so clearly whenever that is what it intended. *See* Maryland Code (1973, 1998 Repl.Vol., 1999 Cum.Supp.) § 5–603 of the Courts and Judicial Proceedings Article.[5]

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5. That section, headed *"Liability for emergency medical care,"* provides:
"(a) A person described in subsection (b) of this section is not civilly liable for any act or omission in giving any assistance or medical care, if:
"(1) The act or omission is not one of gross negligence;
"(2) The assistance or medical care is provided without fee or other compensation; and
"(3) The assistance or medical care is provided:
"(i) At the scene of an emergency;
"(ii) in transit to a medical facility; or
"(iii) Through communications with personnel providing emergency assistance.
"(b) Subsection (a) of this section applies to the following:
"(1) An individual who is licensed by this State to provide medical care;
"(2) A member of any State, county, municipal, or volunteer fire department, ambulance and rescue squad or law enforcement agency or of the National Ski Patrol System, or a corporate fire department responding to a call outside of its corporate premises, if the member:
"(i) has completed an American Red Cross course in advanced first aid and has a current card showing that status;
"(ii) has completed an equivalent of an American Red Cross course in advanced first aid, as determined by the Secretary of Health and Mental Hygiene; or
"(iii) is certified or licensed by this State as an emergency medical services provider;
"(3) A volunteer fire department, ambulance and rescue squad whose members have immunity; and
"(4) A corporation when its fire department personnel are immune under paragraph (2) of this subsection.
"(c) An individual who is not covered otherwise by this section is not civilly liable for any act or omission in providing assistance or medical aid to a victim at the scene of an emergency, if:
"(1) The assistance or aid is provided in a reasonably prudent manner;
"(2) The assistance or aid is provided without fee or other compensation; and
"(3) The individual relinquishes care of the victim when someone who is licensed or certified by this State to provide medical care or services becomes available to take responsibility."
It is interesting to note that in subsection (b)(2), the Legislature distinguished between "State, county, municipal, or volunteer fire de-

[2] The goal with which we approach the interpretation of a statute is to determine the intention of the Legislature in enacting it. The rules governing the conduct of that search are well settled and have been stated by this Court on many occasions. In *Chesapeake and Potomac Telephone Co. of Maryland v. Director of Finance for Mayor and City Council of Baltimore*, 343 Md. 567, 578–79, 683 A.2d 512, 517–18 (1996), this Court said, on the subject:

"[W]e begin our analysis by reviewing the pertinent rules [of statutory construction]. Of course, the cardinal rule is to ascertain and effectuate legislative intent. *Oaks v. Connors*, 339 Md. 24, 35, 660 A.2d 423, 429 (1995); *Montgomery County v. Buckman*, 333 Md. 516, 523, 636 A.2d 448, 451 (1994); *Condon v. State*, 332 Md. 481, 491, 632 A.2d 753, 755 (1993). To this end, we begin our inquiry with the words of the statute and, ordinarily, when the words of the statute are clear and unambiguous, according to their commonly understood meaning, we end our inquiry there also. *Oaks, supra*, 339 Md. at 35, 660 A.2d at 429; *Buckman, supra*, 333 Md. at 523, 636 A.2d at 451; *Condon, supra*, 332 Md. at 491, 632 A.2d at 755; *Harris v. State*, 331 Md. 137, 145–46, 626 A.2d 946, 950 (1993).

"Where the statutory language is plain and unambiguous, a court may neither add nor delete language so as to 'reflect an intent not evidenced in that language,' *Condon, supra*, 332 Md. at 491, 632 A.2d at 755, nor may it construe the statute with " 'forced or subtle interpretations' that limit or extend its application.' *Id.* (*quoting Tucker v. Fireman's Fund Insurance Co.*, 308 Md. 69, 73, 517 A.2d 730, 732 (1986)). Moreover, whenever possible, a statute should be read so that no word, clause, sentence or phrase is rendered superfluous or nugatory. *Buckman, supra*, 333 Md. at 524, 636 A.2d at 452; *Condon, supra*, 332 Md. at 491, 632 A.2d at 755."

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partment, ambulance and rescue squad" and in subsection (b)(4), it was explicit in describing the affected organizations as "a volunteer fire department, ambulance and rescue squad."

This Court has pointed out that, in interpreting a statute, the context in which the statute appears must be considered. *Morris v. Prince George's County*, 319 Md. 597, 604, 573 A.2d 1346, 1349 (1990); *State v. 149 Slot Machines*, 310 Md. 356, 361, 529 A.2d 817, 819 (1987); and that context may include related statutes, pertinent legislative history and "other material that fairly bears on the ... fundamental issue of legislative purpose or goal...." *Kaczorowski v. Mayor & City Council of Baltimore*, 309 Md. 505, 515, 525 A.2d 628, 632 (1987). On this subject, we have instructed:

"Where the statute to be construed is a part of a statutory scheme, the legislative intention is not determined from that statute alone, rather it is to be discerned by considering it in light of the statutory scheme. [*State v.*] *Crescent Cities Jaycees*, 330 Md. [460] at 468, 624 A.2d [955] at 959 [1993]. When, in that scheme, two statutes, enacted at different times and not referring to each other, *Farmers & Merchants [National] Bank v. Schlossberg*, 306 Md. 48, 56, 507 A.2d 172, 176 (1986); *Management Personnel Serv. v. Sandefur*, 300 Md. 332, 341, 478 A.2d 310, 314 (1984), address the same subject, they must be read together, *State v. Bricker*, 321 Md. 86, 93, 581 A.2d 9, 12 (1990), *i.e.*, interpreted with reference to one another, *Schlossberg*, 306 Md. at 61, 507 A.2d at 178; *Bridges v. Nicely*, 304 Md. 1, 10, 497 A.2d 142, 146 (1985), and harmonized, to the extent possible, both with each other and with other provisions of the statutory scheme. *Balto. Gas & Elec. [v. Public Service Com'n of Md.]*, 305 Md. [145] at 157, 501 A.2d [1307] at 1313 [1986]. Neither statute should be read, however, so as to render the other, or any portion of it, meaningless, surplusage, superfluous or nugatory. *Tracey v. Tracey*, 328 Md. 380, 387, 614 A.2d 590, 594 (1992); *D & Y, Inc. v. Winston*, 320 Md. 534, 538, 578 A.2d 1177, 1179 (1990); *Kindley v. Governor of Md.*, 289 Md. 620, 625, 426 A.2d 908, 912 (1981); *Moberly v. Herboldsheimer*, 276 Md. 211, 217, 345 A.2d 855, 858 (1975). In attempting to harmonize them, we presume that, when the Legislature enacted the later of the two statutes, it was aware of the one earlier enacted. *Cicoria v.*

State, 332 Md. 21, 43, 629 A.2d 742, 752 (1993); *Bricker*, 321 Md. at 93, 581 A.2d at 12."

Government Employees Ins. Co. and GEICO v. Insurance Com'r, 332 Md. 124, 131–32, 630 A.2d 713, 717–18 (1993).

Application of these rules produces a clear, logical and predictable result. As we have seen, § 5–604 speaks broadly both as to the immunity it bestows and with regard to its recipients. In this regard, as we have also seen, it is not at all ambiguous.

[3] To be sure, a statute whose terms are unambiguous when the statute is considered by itself, may be rendered ambiguous when viewed in light of a related statute or when that statute is part of a larger statutory scheme. *See Gardner v. State*, 344 Md. 642, 648, 689 A.2d 610, 613 (1997) (statutes that are clear when viewed separately may well be ambiguous where their application in a given situation, or when they operate together, is not clear). That is not the case here, however.

Section 5–603 is relevant to the interpretation of § 5–604 and, therefore, was appropriately considered by the Court of Special Appeals in determining § 5–604's meaning. It predated the enactment of § 5–604 and, thus, its existence and content are presumed to have been known to the Legislature when the later enacted statute was promulgated; it is in essence a part of the context in which § 5–604 must be viewed. Section 5–603 does not, however, affect the clarity of § 5–604; reading the two statutes together does not render § 5–604 ambiguous. Just the opposite is the case. By using the phrase, "[n]otwithstanding any other provision of law," § 5–604 clearly and unambiguously states its relationship to § 5–603 and other statutes or laws on the same subject, prescribing different requirements, that the immunity it provides takes precedence over and prevails as against restrictions made applicable to fire and rescue companies by those other statutes, including § 5–603. It is difficult to imagine how that legislative intent could have been stated any clearer. Even more difficult to imagine is a more reasonable interpretation.

[4] Without any regard to whether the statute is ambiguous and, indeed, without explicitly addressing the point, the respondents argue that when the legislative history is considered, it is apparent that § 5–604 applies to volunteer fire and rescue companies and to private fire companies and their personnel, but not to municipal fire and rescue companies. Aside from the fact that the legislative history on which it relies does not support the conclusion, the respondents misuse that history. It is true, of course, that our cases indicate that even when the language of a statute is free from ambiguity, "in the interest of completeness" we may, and sometimes do, explore the legislative history of the statute under review. *E.g., Harris v. State*, 331 Md. 137, 146, 626 A.2d 946, 950 (1993). We do so, however, to look at the purpose of the statute and compare the result obtained by use of its plain language with that which results when the purpose of the statute is taken into account. *Id.* In other words, the resort to legislative history is a confirmatory process; it is not undertaken to contradict the plain meaning of the statute. *See Coleman v. State*, 281 Md. 538, 546, 380 A.2d 49, 54 (1977) ("a court may not as a general rule surmise a legislative intention contrary to the plain language of a statute or insert exceptions not made by the legislature.").

The respondents submit that it is apparent that the General Assembly intended to extend to non-governmental fire and rescue companies the same immunity that the common law conferred on their governmental counterparts. Curiously, they fail to explain why it is apparent. Nor, as we have seen, other than its reliance on the legislative history, do the respondents explain their disregard of § 5–604's plain language.

The respondents offer yet another reason for interpreting § 5–604 as applicable only to volunteer and private fire and rescue companies: the word "company" is appropriately used only in connection with volunteer or private concerns; their

municipal counterparts are referred to as "departments." That is a slender reed on which to base a matter of statutory construction as important as this. Moreover, while that may be the usual and customary usage, it is not without exception and certainly it is not universally followed by the General Assembly. Indeed, in the very statute that the respondents urge in support of the interpretation they favor, § 5–603, the General Assembly referred to "voluntary fire departments." *See* subsection (b)(2) and (b)(3). Having used terminology usually reserved for municipal entities in the prior section, nothing legitimately can be made of the Legislature's use of terminology more common to references to private entities in § 5–604.

The interpretation of § 5–604 advocated by the respondents is inconsistent with most, if not all of the applicable canons of statutory construction. The respondents disregard, if not ignore, the fact that § 5–604 is not ambiguous at all, that its language is crystal clear. As already pointed out, § 5–604's relationship to pre-existing law and statutes bearing on the immunity of fire and rescue companies is addressed head-on and without equivocation—whatever their provisions in that regard, *i.e.* "Notwithstanding any other provision of law," they do not affect, or survive, the immunity accorded fire and rescue companies by the provisions of § 5–604. That could not be clearer. Indeed, the interpretation the respondents favor and urge us to adopt renders the "notwithstanding" phrase essentially meaningless.

The breadth of § 5–604 can not be questioned; it specifically states that it applies to "any act or omission [of a fire or rescue company, or their personnel] in the course of performing their duties." Nor is there any doubt as to who falls within its grant of immunity. The statute clearly and unequivocally refers to fire or rescue companies; there is no differentiation at all between public and private companies. Indeed, as we have seen, the statute started with that limitation, at its introduction it applied only to volunteer companies, but ended without it, indicating the Legislature's intention, arrived at during the passage of the legislation through the General

Assembly, to broaden its coverage. Of course failure to give effect to the real intention of the Legislature is a clear violation of the rules. Interpreting § 5–604 broadly is neither unreasonable nor illogical, nor a failure to bring common sense to the construction of the statute.

Indeed, an examination of the intent behind § 5–604 leads to the opposite conclusion than the respondents draw. The first amendment made to Senate Bill 731, as seen in notes from the Judicial Proceedings Committee, was the striking of the word "volunteer" as a modifier of fire and rescue companies. The decision to broaden the language of the subject, to simply "fire and rescue companies", clearly indicates a conscious choice to grant immunity to all employed by such companies, and not restrict the grant to only those in volunteer companies. In addition, Senate Bill 731 was considered along with Senate Bill 659, which conferred immunity in negligence actions on operators of emergency vehicles. SB 659 included both government and volunteer vehicles under its grant of immunity. That perhaps provides some insight as to why, in SB 731, the limitation to "volunteer" fire and rescue companies, was dropped.

Thus, it is clear that, whether looking at the plain language of § 5–604, or looking at its legislative intent, § 5–604 grants, and was intended to grant, immunity to fire and rescue companies, be they municipal, or volunteer.

JUDGMENT OF THE COURT OF SPECIAL APPEALS REVERSED. CASE REMANDED TO THAT COURT WITH DIRECTIONS TO DECIDE THE ISSUE OF GROSS NEGLIGENCE WHICH WAS NOT PREVIOUSLY RESOLVED. COSTS IN THIS COURT AND IN THE COURT OF SPECIAL APPEALS TO BE PAID BY THE RESPONDENTS.

RAKER, Judge, dissenting.

Because I conclude that the Fire and Rescue Company Act, Maryland Code (1974, 1998 Repl.Vol., 1999 Supp.) § 5–604 of the Courts and Judicial Proceedings Article, affords Petition-

ers no immunity, I would affirm the judgment of the Court of Special Appeals. Accordingly, I respectfully dissent.

Section 5–604 grants qualified immunity from civil liability for negligence to fire and rescue companies and their personnel. It provides, in pertinent part, as follows:

> (a) *Immunity from Civil Liability.*—Notwithstanding any other provision of law, except for any willful or grossly negligent act, a fire company or rescue company, and the personnel of a fire company or rescue company, are immune from civil liability for any act or omission in the course of performing their duties.

The Court of Special Appeals held that § 5–604 does not apply to municipal fire and rescue departments. *Chase v. Baltimore,* 126 Md.App. at 442, 730 A.2d at 247. The Court of Special Appeals was correct. Respondents argue that when § 5–604 is considered in its context within the Maryland Code and its legislative history, it becomes apparent that the Court of Special Appeals was correct in holding that § 5–604 applies to volunteer fire and rescue companies and to private fire companies and their personnel, but not to municipal fire and rescue companies. I agree.

The Court of Appeals has repeatedly stated that the cardinal rule of statutory interpretation is to ascertain and to give effect to the intent of the Legislature. *See Oaks v. Connors,* 339 Md. 24, 35, 660 A.2d 423, 429 (1995). In determining the intent of the legislature, we look first to the statutory language, and if that is plain and admits of no more than one meaning, our function is to enforce it according to its terms. *See Board of License Comm'rs v. Toye,* 354 Md. 116, 122, 729 A.2d 407, 410 (1999); *Marriott Employees Fed. Credit Union v. Motor Vehicle Admin.,* 346 Md. 437, 444–45, 697 A.2d 455, 458 (1997). This has become known as the "plain-meaning rule." *Kaczorowski v. Mayor and City Council of Baltimore,* 309 Md. 505, 513, 525 A.2d 628, 633 (1987). The rule is not absolute, however. In this regard, we observed that

> While the language of the statute is the primary source for determining legislative intention, the plain meaning rule of construction is not absolute; rather, the statute must be construed reasonably with reference to the purpose, aim, or policy of the enacting body. The Court will look at the larger context, including the legislative purpose, within which statutory language appears. Construction of a statute which is unreasonable, illogical, unjust, or inconsistent with common sense should be avoided.

Tracey v. Tracey, 328 Md. 380, 387, 614 A.2d 590, 594 (1992) (citations omitted). A term "may be free from ambiguity when used in one context but of doubtful application in another context." *Tucker v. Fireman's Fund Ins. Co.,* 308 Md. 69, 74, 517 A.2d 730, 732 (1986). This Court recently stated that "statutory language is not read in isolation, but 'in light of the full context in which [it] appear[s], and in light of external manifestations of intent or general purpose available through other evidence.'" *Stanford v. Maryland Police Training & Correctional Comm'n,* 346 Md. 374, 380, 697 A.2d 424, 427 (1997) (alterations in original) (quoting *Cunningham v. State,* 318 Md. 182, 185, 567 A.2d 126, 127 (1989)). The Court has held that

> [w]here the statute to be construed is part of a statutory scheme, the legislative intention is not determined from that statute alone, rather it is to be discerned by considering it in light of the statutory scheme. When, in that scheme, two statutes, enacted at different times and not referring to each other, address the same subject, they must be read together, *i.e.,* interpreted with reference to one another, and harmonized, to the extent possible, both with each other and with the statutory scheme.

Government Employees Insurance Co. v. Insurance Com'r, 332 Md. 124, 131–32, 630 A.2d 713, 717–18 (1993) (citations omitted).

Although there are times when the statutory language is clearly consistent with the apparent purpose of the legislature and further research is not necessary, there are other times when more extensive inquiry is required. *See Kaczorowski,* 309 Md. at 515, 525 A.2d at 633. The Court has recognized

that "the purpose, in short, determined in light of the statute's context, is the key." *Id.*[1]

In this case, contrary to the majority's view, it is not possible to rely on plain meaning alone in interpreting the statute. First, the term "company" presents an interpretive difficulty. Within this statute, this term is not defined by the Legislature, and the word's meanings in common usage are multiple. The definitions range from "[a] corporation—or, less commonly, an association, partnership or union—that carries on a commercial or industrial enterprise," BLACK'S LAW DICTIONARY 274 (7th ed.1999), to "an assemblage or association of persons or things," WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 461 (1963), and, indeed, to "a fire-fighting unit," *id.* Nor is usage of the term "company" in connection with fire and rescue activities in the Maryland Code entirely uniform; often it refers specifically to volunteer fire and rescue units, *see, e.g.*, Maryland Code (1975, 1999 Repl.Vol.) § 1–203.1 of the Corporations and Associations Article (creating exemption from recording fees for volunteer fire companies), but sometimes it refers to both volunteer and non-volunteer units, *see, e.g.*, Maryland Code (1978, 1999 Repl.Vol.) § 13–509 of the Education Article (providing for comment by "volunteer and career fire companies" on regulations proposed by the Emergency Medical Services Board).

The meaning of § 5–604 is made even more unclear when § 5–604 is read in conjunction with the Good Samaritan Act, Maryland Code (1974, 1998 Repl.Vol., 1999 Supp.) § 5–603 of

1. We noted in *Kaczorowski v. Mayor and City Council of Baltimore*, 309 Md. 505, 525 A.2d 628 (1987) that

> in *State v. One 1983 Chevrolet Van*, 309 Md. 327, 524 A.2d 51 (1987) .... [a]lthough we did not describe any of the statutes involved in that case as ambiguous or uncertain, we did search for legislative purpose or meaning—what Judge Orth, writing for the Court, described as "the legislative scheme." We identified that scheme or purpose after an extensive review of the context of Ch. 549, Acts of 1984, which had effected major changes in Art. 27, § 297. That context included, among other things, a bill request form, prior legislation, a legislative committee report, a bill title, related statutes and amendments to the bill.

Id. at 515, 525 A.2d at 633 (citations omitted).

the Courts and Judicial Proceedings Article. The words "[n]otwithstanding any other provision of law" in § 5–604(a) do not imply that § 5–604 is not to be read in the context of other statutes, as the majority appears to suggest. These words only mean that if a preexisting provision of law conflicts with § 5–604, then § 5–604 prevails. The words do not abrogate the practice of reading statutes in context.

Reading § 5–604 in conjunction with § 5–603 simply shows that the meaning of § 5–604 is not so plain that it can be interpreted without the assistance of the legislative history. In one respect, the enactment of § 5–604 would have duplicated immunity created by § 5–603, if the Legislature had intended that emergency medical services provided by municipal fire departments be covered by § 5–604. As the Court of Special Appeals stated,

> City paramedics and firefighters providing emergency medical care or assistance were already afforded immunity under the Good Samaritan Act [i.e., § 5–603], where applicable. Although the Good Samaritan Act limited the immunity to acts provided "without fee or compensation," the City of Baltimore did not have authority to charge such fees until 1 July 1989. *See* Baltimore City Code, Art. 9, § 12A (1995 Supp.).

Chase, 126 Md.App. at 443, 730 A.2d at 248. To this extent, emergency rescue services provided by municipal fire departments were already covered by an immunity statute. In another respect, § 5–604 would have conflicted with § 5–603 if the legislature had intended § 5–604 to cover municipal fire departments. Because § 5–604 grants immunity regardless of whether a fee was charged for services, "its application to municipal fire departments would circumvent the fee restriction imposed by the Good Samaritan Act," as the Court of Special Appeals observed. *Id.* at 444, 730 A.2d at 248.

The meaning of § 5–604 thus remains unclear, and it is appropriate to turn to the legislative history in an attempt to ascertain the intent of the Legislature. Section 5–604 was

Senate Bill 731 of the 1983 session of the General Assembly. The legislative history of the statute was recounted well by Judge Rodowsky, writing for this Court in *Washington Suburban Sanitary Com'n v. Riverdale Heights Volunteer Fire Co.*, 308 Md. 556, 569, 520 A.2d 1319, 1326 (1987). It reveals that § 5–604 was enacted in response to the holding of the Court of Special Appeals in *Utica Mutual Insurance Co. v. Gaithersburg–Washington Grove Fire Department, Inc.*, 53 Md.App. 589, 455 A.2d 987 (1983), that volunteer fire companies are not necessarily governmental entities and therefore may not be covered by governmental immunity, and may be liable to suit. *See* Senate Judicial Proceedings Committee, Report on Senate Bill 731, at 2 (1983). As to the history, we said:

> Courts & Judicial Proceedings Art. § 5–309.1 [recodified at § 5-604] was Senate Bill 731 of the 1983 Session of the General Assembly. The file of the Senate Judicial Proceedings Committee on S.B. 731 reflects that the legislation was a response to *Utica Mutual Insurance Co. v. Gaithersburg–Washington Grove Fire Department, Inc.*, 53 Md.App. 589, 455 A.2d 987, *cert. denied*, 296 Md. 224 (1983). *Utica Mutual* was a negligence action brought by a fire insurance company, as subrogee of its insured, against a fire company for alleged negligence in failing properly to extinguish a fire which later reignited leading to a second fire. The circuit court had held that the fire company enjoyed governmental immunity but the Court of Special Appeals reversed, holding that whether a fire company enjoyed governmental immunity was a question of fact on which the fire company in *Utica Mutual* had failed to produce sufficient evidence. The intermediate appellate court decided *Utica Mutual* on February 2, 1983, and on February 3, 1983, a member of the Maryland Senate requested the Department of Legislative Reference to prepare a bill granting immunity to volunteer firefighters. As introduced the bill provided that "[a] volunteer fire company is immune from liability in the same manner as a local government agency for any act or omission in the course of performing its duties if [ ] the act or omission is not one of gross negligence. . . ." The bill was amended in the course of passage to its present form.

308 Md. at 569, 520 A.2d at 1326.

It is apparent from this history that in passing § 5–604 the Legislature was responding to *Utica Mutual*, and intended to displace that decision by extending to non-governmental fire companies and their personnel the immunity that the common law at that time conferred on their governmental counterparts. This logic is perhaps less obvious today than it would have been at the time of the passage of § 5–604, because local governmental immunity was subsequently waived to a significant extent, *see, e.g., Downey v. Collins*, 866 F.Supp. 887, 889 n. 3 (D.Md.1994); *Ashton v. Brown*, 339 Md. 70, 107–08, 660 A.2d 447, 465–66 (1995), by the passage of the Local Government Tort Claims Act (LGTCA) in 1987. 1987 Maryland Laws ch. 594 (codified as amended at Maryland Code (1974, 1998 Repl.Vol., 1999 Supp) §§ 5–301 to 5–304 of the Courts and Judicial Proceedings Article). The individuals and entities to which § 5–604 extends immunity today have greater immunity than their governmental counterparts, on account of the waiver effect of the LGTCA. But when we look back to the situation that existed at the time of § 5–604's passage, it is apparent that the point of that enactment was to give non-governmental firefighters and fire companies the same immunity that then existed for their governmental counterparts. I therefore conclude that the Legislature's attention was confined to this objective, and that § 5–604 covers non-governmental individuals and organizations only, and does not create immunity for governmental personnel and organizations that would have been duplicative at the time of enactment.

This point is reinforced by the fact that when the Legislature did intend, in § 5–603, to create duplicative immunity for government-employed paramedics, it did so by naming them explicitly. Section 5–603 confers immunity, as noted above, on "[a] member of any State, county [or] municipal . . . fire department, ambulance and rescue squad or law enforcement agency." Section 5–604 contains no comparable language.

The majority says that in *Washington Suburban Sanitary* we "reject[ed] the Fire Company's argument that [the Fire and Rescue Company Act's] purpose was to reinstate the governmental immunity volunteer companies enjoyed before the *Utica* decision." This is not the proposition we rejected. In *Washington Suburban Sanitary* we said that "Fire Co. is mistaken in its premise that volunteer fire companies generally enjoyed immunity from liability for negligence as instrumentalities exercising a governmental function." *Washington Suburban Sanitary Com'n*, 308 Md. at 570, 520 A.2d at 1326. We went on to point out that Prince George's County had waived governmental immunity, so that the Riverdale Heights Volunteer Fire Company would not have been immune even if it had been an instrumentality of the county. Thus, our point was that volunteer companies never necessarily had governmental immunity before *Utica Mutual*, and those in Prince George's County in particular could not have, because of the waiver. *See id.* We did *not* say that it was not the purpose of the Fire and Rescue Company Act to confer immunity on volunteer companies.

The fact, noted in *Utica Mutual*, *see* 308 Md. at 569, 520 A.2d at 1326, that the bill that became § 5–604 at first referred to "a volunteer fire company or rescue company" but was later amended to refer simply to "a fire company or rescue company" does not alter the analysis. I agree with the Court of Special Appeals that "[a]lthough the term "volunteer" was not included in the final form adopted by the General Assembly, this alone does not presume that the legislature intended to extend the immunity to state, county, or municipal fire departments." *Chase*, 126 Md.App. at 433, 730 A.2d at 247–48. The Attorney General's opinion analyzing a proposed City of Annapolis ambulance fee ordinance examined this issue:

> The City Attorney has expressed doubt ... that CJ § 5–309.1 [now codified as § 5–604] applies to municipal fire departments, and we share that doubt. As we discussed in our prior opinion, "[t]he history of [§ 5–604] indicates that it constituted the legislative response to a decision by the Court of Special Appeals holding that volunteer fire companies are not considered governmental entities entitled to immunity, and that volunteer firemen are not public officials for the purpose of governmental immunity." Opinion No. 87–055, at 6 n. 6. When the bill was introduced, it expressly limited the grant of immunity to "volunteer" fire companies. *See* Senate Bill 731 of the 1983 Session. According to the hearing summary of the Senate Judicial Proceedings Committee, "the purpose of this bill is to protect volunteer fire departments from liability arising from suits which do not involve acts of gross negligence." The committee then adopted an amendment that deleted the original provisions and extended the immunity to fire and rescue companies, without the modifier "volunteer." Nevertheless, even after the amendment, the committee identified the "background" problem as the fact that "few people would volunteer to serve the fire departments, if they realized that they could be subject to liability for their acts."

80 Op. Att'y Gen. No. 95–020 (June 9, 1995).

In sum, the Court of Special Appeals held § 5–604 does not apply to municipal fire and rescue departments. I agree, and would hold that § 5–604 therefore affords Petitioners no immunity.

Judge ELDRIDGE and Judge WILNER have authorized me to state that they join in the views expressed in this dissenting opinion.